Healthy Kids, Healthy Michigan Childhood Obesity Prevention Summit

March 24, 2008
Lansing, MI

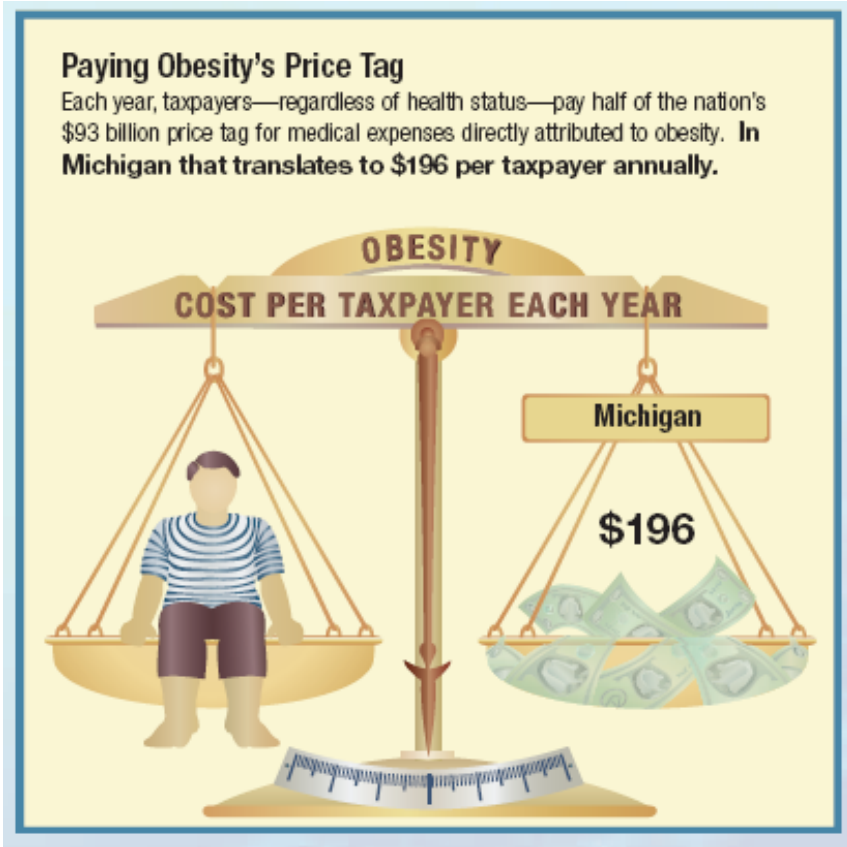
Healthy Kids, Healthy Michigan Childhood Obesity Prevention Workgroup

Agenda

- 1:00 – Welcome and Overview of Today's Events
- 1:20 – Consensus Process
- 1:30 – Education Policy Action Team
- 2:10 – Health, Family and Child Care Services Policy Action Team
- 2:50 –10-Minute Stretch Break
- 3:00 – Community Policy Action Team
- 3:40 – Future Strategies for the COPW
- 3:50 – Consensus Results: Priority Policies for Year 1
- 4:00 – Adjourn

Childhood Obesity Michigan

- 1 in 4 adolescents is overweight
- Low income and minority populations are disproportionately affected
- 70-80% of overweight children become obese adults
  - Michigan adults have 5th highest rate of obesity in the country
- Obesity is associated with physical, psychosocial, and economic consequences



Why is this Happening?

An Imbalance in energy intake and expenditure:

- More food eaten away from home
- Larger portion sizes
- Reduced physical activity in schools
- Lack of safe areas to play
- Increased screen time
- Urban sprawl

Healthy Kids, Healthy Michigan

- 1 of 15 states funded by National Governor's Association *Healthy Kids, Healthy America* program
- Collaborative effort between Governor's Office, Office of the Surgeon General, MDCH and MDE
- Focus on *policy* change to reduce childhood obesity
- Deliverable--5-year policy agenda

State Leadership

- Michigan Surgeon General
  - Lead Childhood Obesity Prevention Workgroup
- Michigan Departments of Community Health and Education
  - Provide technical assistance and staff support to Policy Action Teams
  - Repository of information on policy strategies across the nation
  - Liaison between COPW and NGA

Grant Overview

- Outcome
  - A comprehensive, multi-year statewide policy agenda to prevent childhood obesity in Michigan.
- Grant components
  1. Statewide Environmental Scan
  2. Mini-grants to school districts
  3. Childhood Obesity Prevention Workgroup

Current Strategies to Prevent Childhood Obesity in Michigan

- In Schools
  - Consensus and State Board of Ed recommendations
  - Form school teams and complete assessments
  - Environmental changes to cafeteria, vending, etc.
  - Evidence-based curricula
- In Communities
  - Safe Routes to School programs
  - Farmers' markets, community gardens, walking trails
  - Faith-based initiatives
- In Healthcare
  - Consensus recommendations, toolkit

Current Strategies Overall

- Support for change
- Many recommendations, programs, and resources, few policies
- Changes at policy and environmental levels are not widespread
- Coordination and standardization of practices is missing

Why Policy? Why Now?

- Population-wide strategy, large reach and potential for impact
- Enhanced coordination across state-standardization
- Equalize efforts across low and high income areas
- Research for obesity determinants is clear-6 key target areas

Childhood Obesity Prevention Workgroup (COPW)

- **Purpose:** To create the 5 year strategic policy agenda to reduce childhood obesity in Michigan
- **Participants:** Executive-level leaders representing diverse settings and interests

TIMELINE October ’07-October ‘08

Commit support, staff on committee

Present Action Team policy options, provide input

Provide feedback and input on draft agenda

Sign and support agenda

Oct ‘07

Mar ‘08

July ‘08

Oct ‘08

Recruit additional participants

Create agenda for March Summit meeting

Presentations for Summit

Build consensus for policy strategies

Prioritize policies into a draft agenda

Draft policy items

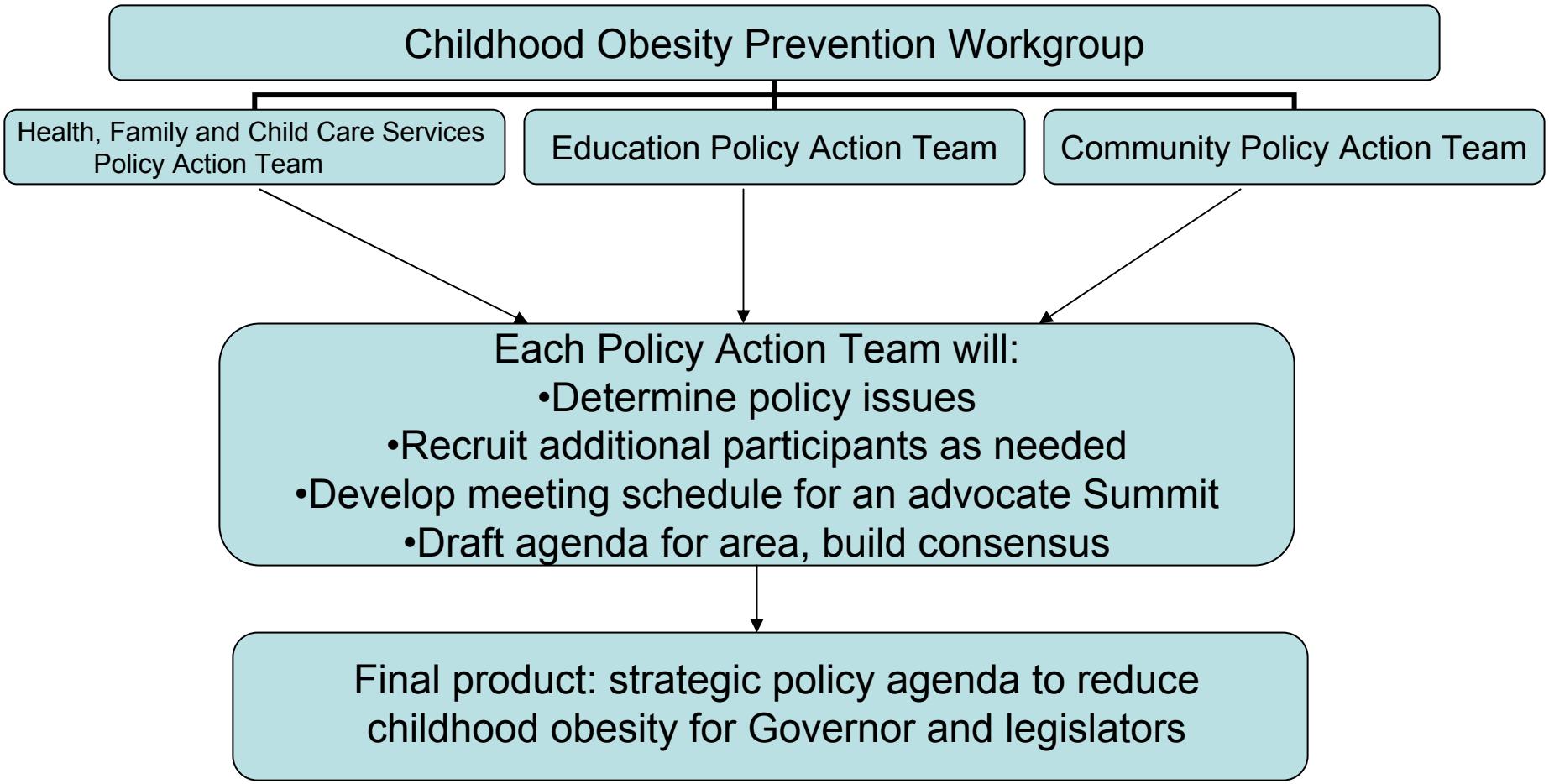
Prioritize in final draft form

Prepare presentation for group

COPW Process

- **Meeting 1 (**October 29, 2007) Outcome:
  - Steering committee broke out into Policy Action Teams to create plans for future meetings and determine how they will function to achieve goals over the next year
- **Meeting 2** (Summit-Today) Outcome:
  - Policy Action Teams present on both sides of policies put forth, build consensus among participants
- **Meeting 3** (July 9) Outcome:
  - Draft agenda of policy plan created in Policy Action Teams is reviewed and actions prioritized; agreement on items or plans for revision
- **Meeting 4** (October, TBD) Outcome:
  - Final plan is endorsed by participating organizations

Policy Action Teams



Thank You for Your Leadership!

Policy Action Team Co-Chairs:
Kate Conway
Gloria Edwards
Tom Peterson
Kirsten Simmons
Debbie Squires
Dru Szczerba

Staff Support:
Shannon Carney Oleksyk
Lisa Grost
Kyle Guerrant
Karah Mantinan

Goals for Today's Meeting

1. Hear the recommendations from three Policy Action Teams.
2. Gain consensus on priority policies for the first year of the 5-year childhood obesity policy agenda.
3. Provide information for future direction of the Workgroup efforts.

Consensus Process: Prioritizing the Policy Recommendations

Matt Longjohn, MD, MPH
Consultant to Michigan
Department of Community Health

Criteria for the Development of a Consensus Policy Agenda

- **Need**—What is your current view of the relative importance of this policy concept to the State's overall effort to address childhood obesity?
  Can we adequately address the epidemic without this policy?
- **Evidence**—What is your current understanding of the relative strength of the evidence behind the policy approach being discussed.
  What is the likelihood that this policy will be effective?
- **"Pass-ability"**—What is your current view of the receptivity to this policy change in the political or bureaucratic system?
  What is the likelihood that we can get this policy change to occur?
- **Advocacy**—What is your perception of the support this policy change would receive from advocates around the State?
  Will your organization help develop and/or advocate for this policy?
- **Consensus**—If this is included in a year one agenda, will it keep your organization from supporting other identified policies?
  Is this a potential deal-breaker for your organization?

Sample Voting Table

Check 2 Priorities	Policy Recommendations	Concerns
☑	1. Menu labeling in restaurants	
☐	2. Tax on soft drinks	May lack public support
☑	3. Zoning out fast food	

Education Policy Action Team

Dru Szczerba

Director of Cancer Prevention and Healthcare Systems
at American Cancer Society

Education Policy Action Team

- Altarum Institute
- American Cancer Society
- American Heart Association - Midwest Affiliate
- Family and Consumer Science Educators of Michigan
- *Generation With Promise* Initiative
- Governor’s Office
- Jackson Public School District
- Lansing School District
- Medical Weight Loss Clinic, Inc.
- Michigan After School Partnership - Mayor's Time
- Michigan Department Of Community Health
- Michigan Department Of Education
- Michigan Distributors and Vendors Association
- Michigan Fitness Foundation
- Michigan Parent Teacher Association
- Michigan Soft Drink Association
- Michigan State Nutrition Action Plan
- Mott Children's Health Center
- Parent Action for Healthy Kids
- Taylor School District
- Utica Schools
- YMCA of the USA

Recommendations

1. Local Wellness Policy: Mandating Coordinated School Health Programs
2. Recess Before Lunch
3. Model School Beverage Guidelines
4. Senate Bill 508: Physical and Health Education
5. Health & Physical Education MEAP Testing
6. State Nutrition Standards for the School Campus
7. Expand School Breakfast Participation

Local Wellness Policy: Mandating Coordinated School Health Programs

Dru Szczerba

Director of Cancer Prevention and Healthcare Systems at American Cancer Society

Local Wellness Policy: Mandating Coordinated School Health Programs

- Became Law – June 30, 2004
- Section 204 of the Child Nutrition and WIC Reauthorization Act of 2004
- Michigan State Board of Education adopted a model Local Wellness Policy in 2005
  - In that policy, the Board recommended that Coordinated Health Teams be formed to create and implement district local wellness policies

*This is NOT a mandate of Michigan School Districts

Mandating CSHP

- We’re not alone…
  - In 2006, ten states introduced legislation establishing Coordinated School Health Teams to implement LWP
  - Of those ten states, four have enacted legislation requiring the formation of Coordinated School Health Teams or Local Wellness Councils (IN, KY, MS, PA)

Mandating CSHP

- Education Policy Action Team Recommendation:
  - *All school districts in MI will form a Coordinated School Health Team designated to oversee LWP implementation and other district school health related programming and initiatives.*

Mandating CSHP

- Key functions of these teams include:
  - Assessing the school health environment
  - Creating and implementing a healthy school improvement plan
  - Monitoring and evaluating progress towards achieving the goals of the plan
  - Reporting successes and barriers of implementation to the Department of Education

Recess Before Lunch

Dru Szczerba

Director of Cancer Prevention and Healthcare Systems at American Cancer Society

Recess Before Lunch

- Beverage waste decreased (at one school by 67% & then 79%)
- The lunchroom atmosphere was more relaxed, quiet, & conducive to eating
- Dramatic decrease in discipline problems on the playground, lunchroom, & classroom
- Students liked being able to play first

When Recess is Scheduled Before Lunch:

- Overall plate/food waste decreased from 40.7% to 27.2%
- Nutrient intake increased ; study found increases in calcium, iron and vitamin A.
- Academic Performance enhanced (anecdotally reported)
- Children are more settled upon returning to the classroom (anecdotally reported)

Recess Before Lunch

- Low cost to implement
- Biggest hurdle:
  - Scheduling changes
  - Some school facilities may not be able to accommodate (e.g. lunchroom serves as the gym for physical education classes)

Steps for Implementation

- **Year 1 Activities:**
  - Partner w/an institute of higher education to evaluate pre/post intervention among a select group of pilot sites
- **Years 2-5:**
  - Policy development based on pilot results and additional considerations:
    - Allow adequate time to eat lunch (20 min. minimum)
    - Don’t use recess as a punishment for bad behavior
    - Offer free play in addition to structured play opportunitie or incentives

Model School Beverage Guidelines

of the Alliance for a Healthier Generation

Bill Lobenherz, President

Michigan Soft Drink Association

MODEL SCHOOL BEVERAGE GUIDELINES

Developed by Alliance for a Healthier Generation
a Joint Initiative of the:
American Heart Association
William J. Clinton Foundation

- Limits Portion Sizes
- Limits Calories
- Campus-wide Application
- Regular and Extended Day
- Eliminates Full Calorie Soft Drinks

MODEL SCHOOL BEVERAGE GUIDELINES

of the Alliance for a Healthier Generation

- American Association of School Administrators
- American Beverage Association
- American Cancer Society
- American Dental Association
- American Diabetes Association
- American Dietetic Association
- American Federation of Teachers
- American Medical Association
- American Public Health Association

MODEL SCHOOL BEVERAGE GUIDELINES
of the Alliance for a Healthier Generation

- Cadbury Schweppes
- Center for Science in the Public Interest
- Coca-Cola
- Consumer Federation of America
- Food Research and Action Center
- National Assn. of County and City Health Officials
- National Association of School Nurses
- National Education Association
- National PTA
- PepsiCo, Inc.

MODEL SCHOOL BEVERAGE GUIDELINES

of the Alliance for a Healthier Generation

- **Elementary Schools**
  - Bottled Water
  - Fat-free or Low-fat Milk
  - 100% Juice
  - 8-Ounce Limit on Servings
  - No Full-Calorie Beverages

- **Middle Schools**
  - Same as Elementary, but 10 Ounces
- **High Schools**
  - Portions to 12-Ounces
  - Add No- and Low-calorie Options

Recommendation: Soft Drink Resolution
MODEL SCHOOL BEVERAGE GUIDELINES

- Michigan Legislature Adopt by Concurrent Resolution
- Commend to Schools for their Wellness Policy
- Publish on DOE Website
- Track School District Progress & Annually Report
- Progress Report (Nationally) 2004-2007:
  - 41% Cut in Beverage Calories Shipped to Schools
  - 45% Reduction in Shipments of Full-Calorie Drinks
  - 35% Of Contracts Between Schools and Bottlers in Compliance

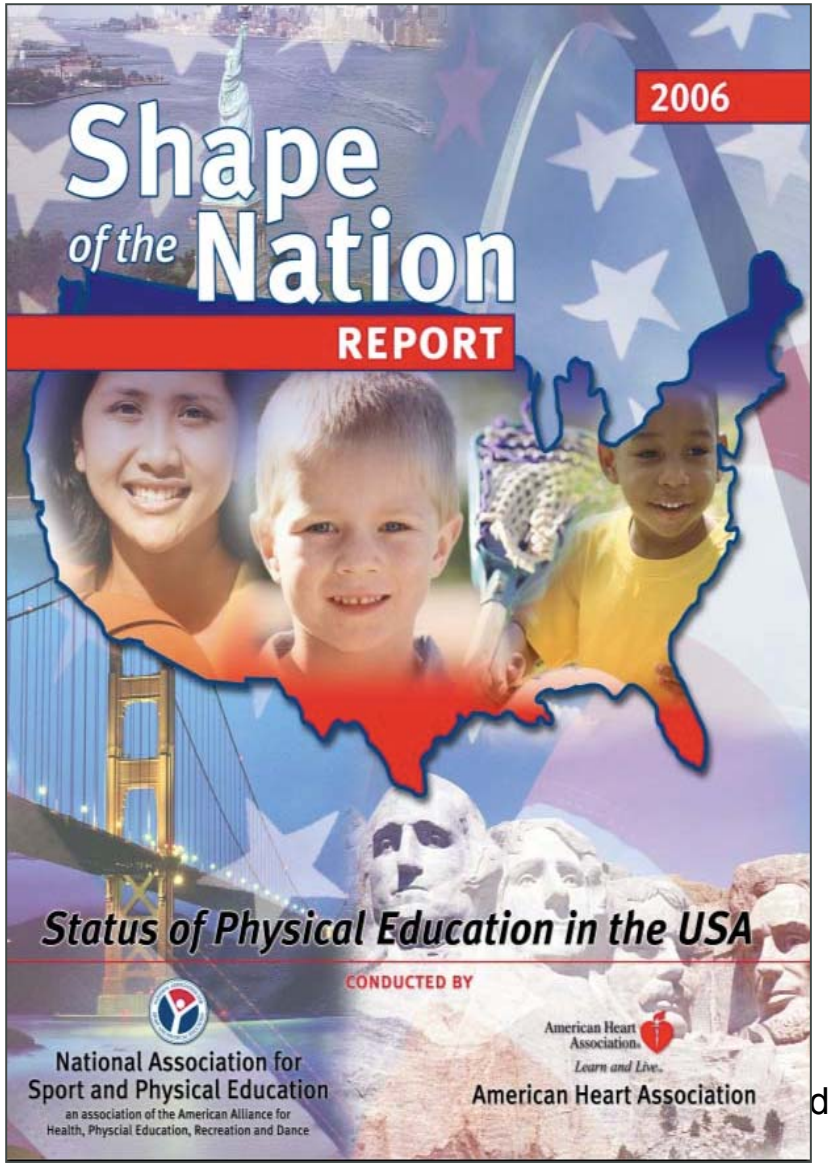
Senate Bill 508
Physical Education

Glenna DeJong, PhD
Vice President of Educational Programs,
Governor's Council on Physical Fitness

Current Michigan Law
Health and Physical Education

- Sec. 380.1502
- (1) Health and physical education for pupils of both sexes shall be established and provided in all public schools of this State. Subject to subsection (2), each pupil attending public school in this State who is physically fit and capable of doing so shall take the course in physical education.
- (2) A school district may credit a pupil's participation in extracurricular athletics or other extracurricular activities involving physical activity as meeting the physical education requirement for the pupil under subsection (1).

Shape of the Nation Report



For more information, contact:
Paula Keyes Kun (703) 476-3461; pkun@aahperd.org

Shape of the Nation Report

MICHIGAN AMONG WORST IN THE NATION FOR PHYSICAL EDUCATION REQUIREMENTS

RESTON, VA, May 15, 2006 – With no state requirements for physical education at the elementary, middle or high school levels, Michigan has been identified by the National Association for Sport and Physical Education (NASPE) as one of the worst states in the country for physical education requirements. Those are among the findings of the latest *Shape of the Nation Report: Status of Physical Education in the USA*, recently released by NASPE and the American Heart Association (AHA).

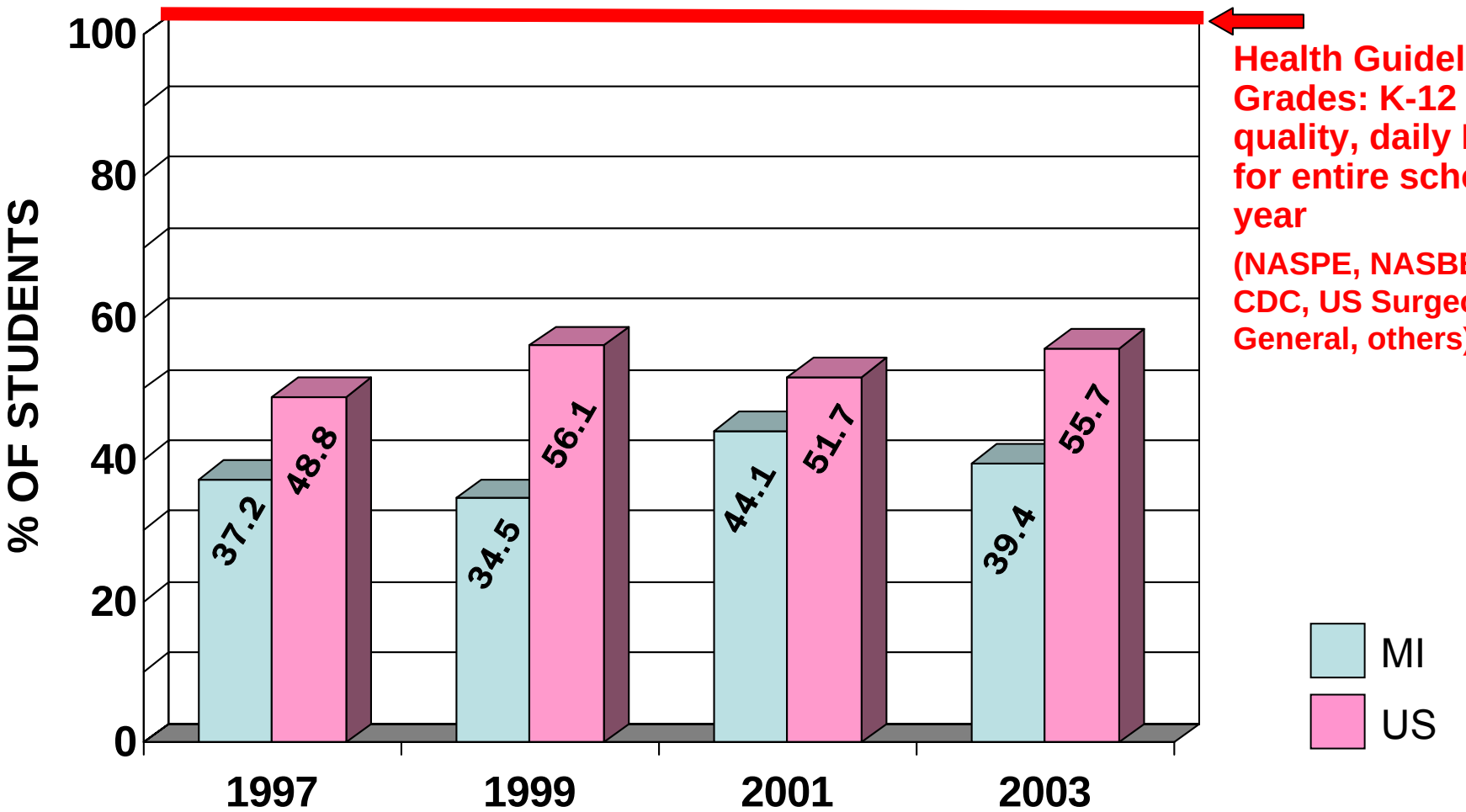
"Despite skyrocketing childhood obesity rates and calls from Congress, the Surgeon General and Centers for Disease Control and Prevention for high quality daily physical education programs, most states join Michigan in receiving a failing grade on their physical education requirements," said NASPE Executive Director Charlene R. Burgeson. "In fact another federal initiative, the No Child Left Behind Act (NCLB) of 2001, is threatening the amount of time available for physical education. NCLB focuses on student achievement in defined core academic subjects. As states develop or select standardized tests to hold schools and students accountable, content that is not tested, such as physical education, has become a lower priority."

→ Conducted every five years the purpose of the ***Shape of the Nation Report*** is to provide current information about the status of physical education in each state and the District of Columbia in the following areas: time requirements, exemptions/waivers and substitutions, class size, standards, curriculum and instruction, student assessment, teacher certification, National Board Certification, state physical education coordinator and body mass index collection. For the complete report, visit www.naspeinfo.org.

dh

PE Survey 2000, MDOE

Enrolled in Physical Education Class



Health Guideline Grades: K-12 quality, daily PE for entire school year

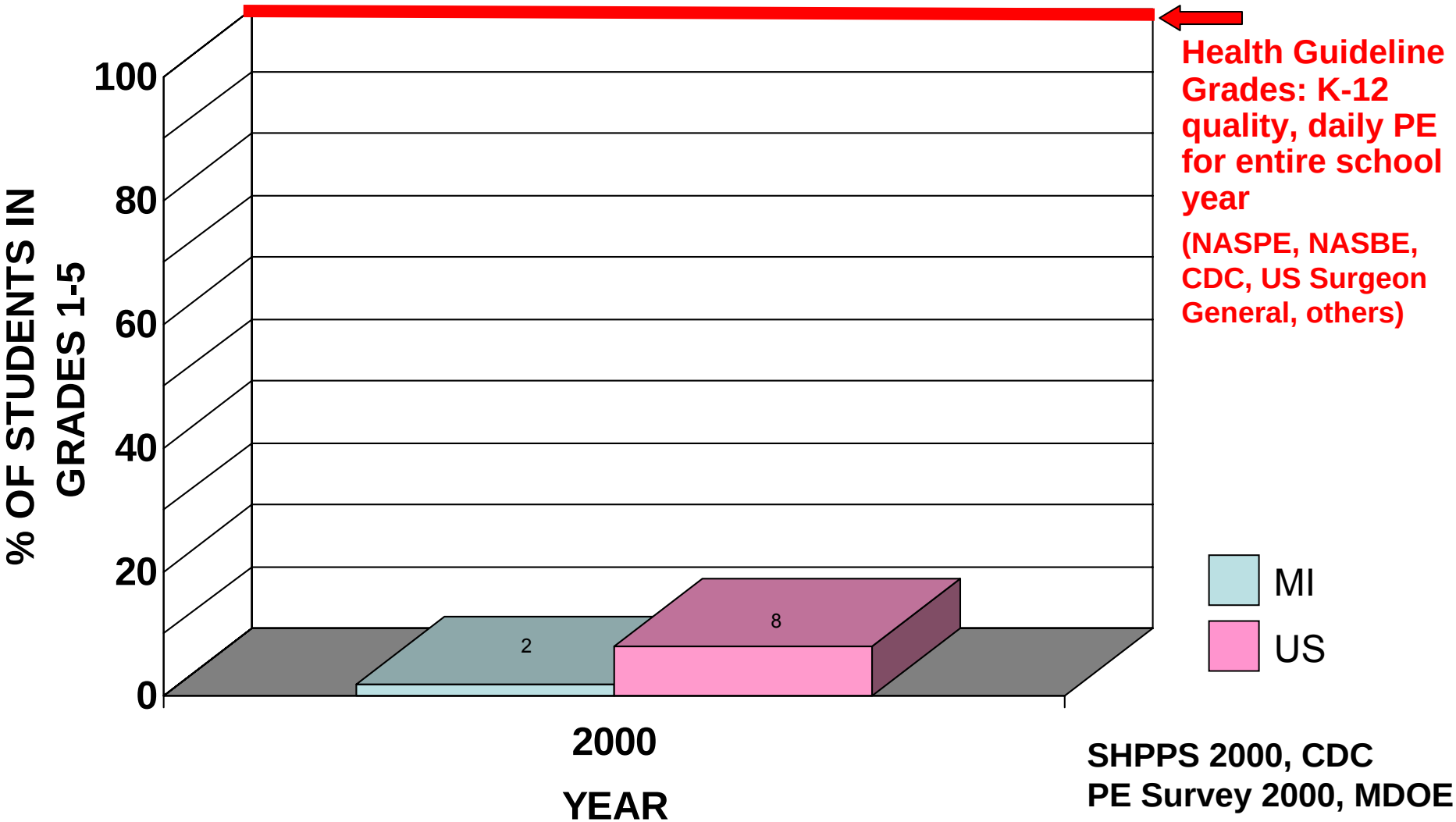
(NASPE, NASBE, CDC, US Surgeon General, others)

*On one or more days in an average week when in school.

Youth Risk Behavior Survey (YRBS), CDC

Healthy Kids, Healthy Michigan Childhood Obesity Prevention Workgroup

Require Physical Education Class Daily



SHPPS 2000, CDC
PE Survey 2000, MDOE

Physical Education vs. Physical Activity

•There is confusion about the difference between *physical activity and physical education* which sometimes leads to the incorrect conclusion that physical education can be addressed through recess or merely running kids around.

•*Physical activity* is a behavior.

•*Physical education* is a curricular area that helps students develop needed skills, knowledge, attitudes and fitness levels while being physically active.

Recommendation

- Education Policy Action Team Recommendation:
  - *Mandate quality health and physical education for all students grades K-12.*

SB 508 & HB 4790

- Incrementally increase time for Physical and Health Education to 5-days-per-week in all grades by 2015.
- Eliminate substitution clause - students would no longer be allowed to substitute participation in other activities for Physical Education.
- Ensure that the student:teacher ratio is consistent with that of other subject areas.
- Encourage schools providing more Physical/Health Education than that listed to continue to do so.
- Report to the legislature with bi-annual data on physical education and health education practices and curriculum requirements (MDE and MDCH).

Senate Bill 282

- Sec. 380.1502
- (1) Health and physical education for pupils of both sexes shall be established and provided in all public schools of this State. Subject to subsection (2), each pupil attending public school in this State who is ~~physically fit and~~ ~~capable of doing so~~ shall take ~~the course in~~ physical education.
- ~~(2) A school district may credit a pupil's participation in extracurricular athletics or other extracurricular activities involving physical activity as meeting the physical education requirement for the pupil under subsection (1).~~

K-5 Physical Education, 2 days/week, 30 minutes/period

Health & Physical Education MEAP Testing

Barb Flis, Founder

Parent Action For Healthy Kids

Health & PE MEAP

- **Background**
  - Schools are under enormous pressure to raise academic achievement in “core” areas (e.g. Math, Science, etc.)
  - Schools feel pressure to use significant amounts of instructional time to focus on “core” areas
  - Health and Physical Education instruction time has suffered under these pressures

Health & PE MEAP

- History
  - Health and PE MEAP's have been conducted in MI before; first in the mid-1970's, and as recent as the fall of 1992
  - Tests varied in grade levels, but provided a snapshot at the elementary, middle and high school level

Health & PE MEAP

- What are the Goals of a Health & PE MEAP?
  - Provide data on the current status of health knowledge and skills among MI students
  - Link this data with other health and education outcome data regarding school health programs and policies
  - Identify a stronger link between health and academics

Health & PE MEAP

- What would it look like?
  - Tests would take place in Grades 4,7, and 9
  - The tests would be developed based on the State Board of Education adopted Grade Level Content Expectations for both Health and Physical Education
  - Implementation would take place in the fall

Steps for Implementation

- **<u>Year 1 Activities:</u>**
  - Build upon existing efforts
    - Work with Institutions of Higher Education to develop test and protocol
    - Pilot in voluntary school districts
- **<u>Years 2-5:</u>**
  - Incorporate Health and Physical Education MEAP test into State MEAP requirements

State Nutrition Standards for the School Campus

Nicholas B. Drzal, MPH, RD
School District Consultant
Michigan Department of Education
Coordinated School Health & Safety Programs

State Nutrition Standards for the School Campus

- School meal programs include:
  - National School Lunch Program (NSLP),
  - School Breakfast Program
  - Afterschool Snack Program
  - Special Milk Program
  - Summer Food Service Program
  - Summer Camp Special Milk Program

State Nutrition Standards for the School Campus

- MDE National School Lunch Program (NSLP) oversees 1030 sites (4,106 buildings)

- Average Daily Participation
  - **NSLP** - 813,901 students, 177.8 Million (USDA), 19.6 Million (MI)
  - **SBP** - 215,129, 46.4 Million (USDA), 8.3 Million (MI)

State Nutrition Standards for the School Campus

- Current national USDA school meals standards require:
  - School lunches must meet the applicable recommendations of the Dietary Guidelines for Americans
    - No more than 30 percent of an individual's calories come from fat, and less than 10 percent from saturated fat.
    - Must provide one-third of the Recommended Dietary Allowances of protein, Vitamin A, Vitamin C, iron, calcium, and calories.
    - Specific foods served and how they are prepared made by local school food authorities.

State Nutrition Standards for the School Campus

- School Meals Initiative (SMI) = Nutrition reviews
  - Started in 1998
  - Once every 5 years each sponsor of a school meal program is reviewed to ensure compliance with USDA standards.

The Competitive Food Environment

Ala Carte Sales
School Parties
Fundraisers
School Stores
Vending
Boosters
School Board
Athletics
Student Clubs

Federally Regulated School Meal Program

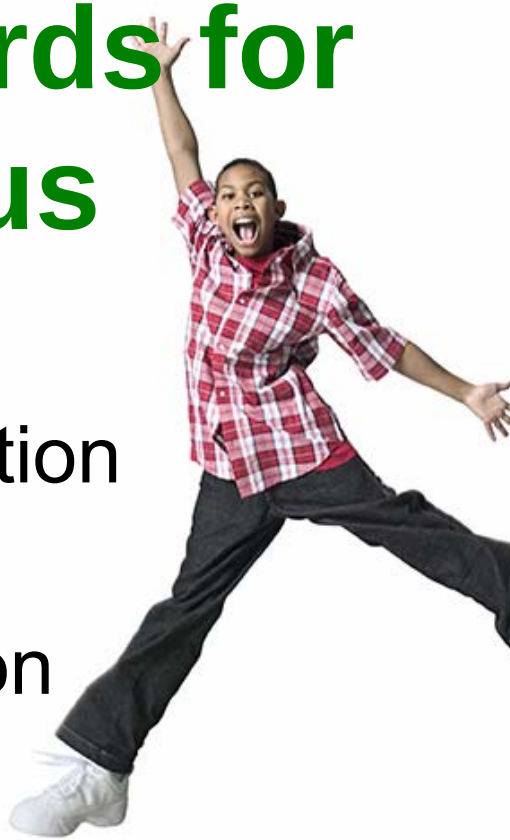
State Nutrition Standards for the School Campus

- MDE follows USDA nutrition standards however:
  - Seventeen states set nutritional standards for school lunches, breakfasts, and snacks that are stricter than existing U.S. Department of Agriculture (USDA) requirements.
  - Twenty-two states have nutritional standards for competitive foods sold a la carte, in vending machines, in school stores, or in bake sales in schools.
  - Twenty-six states limit when and where competitive foods may be sold beyond federal requirements.

State Nutrition Standards for the School Campus

- **2003 -** MDE SBOE Policy on Offering Healthy Food and Beverages In Venues Outside of the Federally Regulated Child Nutrition Programs
- **2004 -** Section 204 of Public Law 108-265 - Child Nutrition and WIC Reauthorization Act
- **2005 -** MDE SBOE Model Local Wellness Policy

State Nutrition Standards for the School Campus



- **2007 –**
  - Institute of Medicine (IOM) Nutrition Standards for Foods in Schools
  - Draft School Nutrition Association Guidelines and Standards.
  - USDA SP 04-2008 Memo – Incorporating the 2005 Dietary Guidelines for Americans into School Meals

State Nutrition Standards for the School Campus

- **2008 -**
  - NGA Education Group requests feedback from MDE regarding IOM and SNA standards.
  - Internal MDE Group formed to generate consensus standards document (in process).

Expand School Breakfast Participation

Nicholas B. Drzal, MPH, RD
School District Consultant
Michigan Department of Education
Coordinated School Health & Safety Programs

Expand School Breakfast Participation

- **Background:**
  - Michigan's overall participation rate is low
  - Some Michigan schools are well below State average participation rate
  - Children are "food insecure"

Michigan School Breakfast Report 3/08

Expand School Breakfast Participation

- **Policy Recommendation:**
  - Schools with 90% or greater free and/or reduced price school meal eligible students will implement and/or expand a universal breakfast programs (i.e. breakfast at no charge) with effective district-wide promotion.

.

Expand School Breakfast Participation Key Points

- MI loses out on millions in federal funding
- Making breakfast readily available during the school day is the most successful
- Participation by at risk students has shown:
  - Reduced tardiness and absenteeism
  - Decreases in hunger
  - Greater cognitive achievements (improvements in math scores)
  - Few disciplinary problems

Expand School Breakfast Participation Key Points

- Is there a link between breakfast and body weight?
  - No evidence to suggest that promoting breakfast consumption contributes to overweight
  - In fact, children who skip breakfast are more likely to be overweight
  - A healthful breakfast (variety of foods, especially high fiber, and nutrient rich whole grains, fruits and dairy products) is associated with reduced BMI

Steps for Implementation

- **<u>Year 1 Activities:</u>**
  - Build upon existing efforts
    - Statewide partners are implementing a Michigan School Breakfast Challenge
      - By the May 2010, I challenge all Superintendents to increase school breakfast participation in their district by 50%.
  - Enforce Current MI law
    - School breakfast is required in schools with 20 percent or more F&RP eligible students during the immediately preceding school year. MICH. COMP. LAWS 380.1272a
- **<u>Years 2-5:</u>**
  - Incorporate in State Nutrition Standards Policy requirements

Education Policy Action Team

Q & A

Health, Family and Child Care Services Policy Action Team

Tom Peterson, MD

Medical Director of Quality and

Healthier Communities at Spectrum Health and Helen DeVos Children's Hospitals

Health, Family and Child Care Services Policy Action Team

- Altarum Institute
- American Academy of Pediatrics, Michigan Chapter
- American Diabetes Association, Michigan Chapter
- American Heart Association-Midwest Affiliate
- Arab Community Center for Economic & Social Services (ACCESS)
- Association for Child Development
- Beaumont Hospital Healthy Kids Program
- Blue Cross Blue Shield of Michigan
- Center for Childhood Weight Management
- CHASS/REACH Detroit 2010
- Children's Health Initiative Program (CHIP)
- Children's Hospital of Michigan
- Henry Ford Health System-School-Based and Community Health Program
- Interfaith Health & Hope Coalition
- Medical Weight Loss Clinic, Inc.
- Michigan Academy of Family Physicians
- Michigan Association for the Education of Young Children
- Michigan Association of School Nurses
- Michigan Community Coordinated Child Care Association
- Michigan Department Of Community Health
- Michigan Department of Education Early Childhood Division
- Michigan Dietetic Association
- Michigan Head Start Association
- Michigan Health & Hospital Association
- Michigan State University Center for Economic Analysis
- Michigan State University Department of Pediatrics and Human Development
- Pritikin Longevity Center
- Spectrum Health and Helen DeVos Children's Hospitals
- St. Joseph Mercy Hospital
- UnaSource Comprehensive Weight Control Program
- University of Michigan C.S. Mott Children's Hospital
- University of Michigan Prevention Research Center
- University of Michigan Program for Multicultural Health
- YMCA of The USA

Team Process

- Recruited additional partners to the table
- Developed a 4-question framework:
  1. What data is available? What data do we need and how do we retrieve it?
  2. What and how many policy options do we want to pursue based on the baseline data?
  3. What is the process of implementing the policy?
  4. Where and who do we want the policy agenda to impact?
- Reviewed national policy examples in relevant areas and selected 3 relevant policies for each Team focus area
- Gathered additional data from research, national experts, lessons learned other states
- Presented proposals to Team for consensus and refined based on feedback

Recommendations

1. Establish a formal childhood obesity task force or commission
2. BMI Surveillance
3. Medicaid coverage of childhood obesity treatment services
4. Implement a 60 minutes per day minimum physical activity requirement for all licensed child care
5. Provide financial incentives for child care providers to serve fresh fruits and vegetables
6. Remove juice as a reimbursable option every time a fruit or vegetable is required

Recommendation: Establish a Childhood Obesity Task Force

- Formalized steering committee to lead/oversee implementation of Childhood Obesity Prevention Workgroup policies and push them forward
- Modeled after enacted Oklahoma bill
  - (OK – SB708 – 2001) Establishment of a taskforce for promotion of children's health. Consists of various members with representation from local government, mental health, healthcare, school counselor and children's advocate for Hispanic and African American population. Assigned to study the ability of these entities to address problems of obesity and investigate best practices at schools including participation in YRBS, healthy vending, and community coalitions.

Establish a Childhood Obesity Task Force

- No cost option
- Greater accountability of members
- Demonstrated success
  - Oklahoma went from an “F” to a “B” rating in one year in efforts to fight obesity
  - Developed the Oklahoma Fit Kids Coalition out of the task force
  - Coalition’s three-bill legislative package has passed through committee

BMI Surveillance

Amy R. Sheon, Ph.D., M.P.H.

Altarum Institute, Ann Arbor

BMI Surveillance

Writing Team

- Kate Conway, President, National Assembly on School-Based Health Care; Henry Ford Health System
- Judy Levine, Michigan Department of Education Early Childhood Division
- Amy R. Sheon, Senior Policy Analyst, Altarum Institute
- Denise Sloan, Executive Director, Michigan Chapter, American Academy of Pediatrics
- Linc Smith, President and CEO, Altarum Institute
- Errol I. Soskolne, MD, Chair, Department of Pediatrics, St. Joseph Mercy Hospital
- Lorraine Thorenson, Michigan Department of Education Early Childhood Division

BMI Surveillance Policy

- **What:** Clinician reporting of height and weight of children at age 2 and kindergarten entry; expand to 6th grade and explore 3rd and 9th grade in future years.
- **How:** Clinician input ht/wt into MCIR.
- Computer calculates BMI and percentiles from standard tables.
- MDCH monitors de-identified data.

Why BMI?

- Optimal method for both screening and surveillance
- Consistent with national (IOM) and prior Michigan calls for data
- Fills gap of YRBS
- Empiric vs. self reported
- Universal vs. sample

The NEW ENGLAND JOURNAL of MEDICINE

ESTABLISHED IN 1812 DECEMBER 6, 2007 VOL. 357 NO. 23

Childhood Body-Mass Index and the Risk of Coronary Heart Disease in Adulthood

Jennifer L. Baker, Ph.D., Lina W. Olsen, Ph.D., and Thorkild I.A. Sørensen, M.D., Dr.Med.Sci.

"*Government, industry, communities, and schools should expand or develop relevant surveillance and monitoring systems*" --IOM

"*…improve the capacity of the healthcare system to prevent, detect and manage overweight and obesity"—Michigan Healthy Eating and Physical Activity Plan*

Why Clinics versus Schools

- No Child Left Behind
- Headlee Amendment—no school mandates without funding
- Arkansas backlash
- Convergence of forces favoring clinical setting

4 Exogenous Factors Favoring Clinical Setting

AMA Recs

PEDIATRICS®

OFFICIAL JOURNAL OF THE AMERICAN ACADEMY OF PEDIATRICS

Expert Committee Recommendations Regarding the Prevention, Assessment, and Treatment of Child and Adolescent Overweight and Obesity: Summary Report

Sarah E. Barlow and and the Expert Committee

Pediatrics 2007;120;S164-S192

DOI: 10.1542/peds.2007-2329C

HEDIS

Draft Document for HEDIS 2009 Public Comment—Obsolete after March 14, 2008

Body Mass Index (BMI) Percentile Assessment and Counseling for Nutrition and Physical Activity (BCA)

SUMMARY OF CHANGES TO HEDIS 2009

- First-year measure.

Description

The percentage of members 2–17 years of age who had an outpatient office visit and who had evidence of the following during the measurement year.

- BMI percentile assessment
- Counseling for nutrition
- Counseling for physical activity

Pediatric Healthy Weight Toolkit

A Toolkit for Health Professionals

Kids and Teens
Weight Management
Healthy Eating Habits
Physical Activity

Blue Cross Blue Shield of Michigan

Healthy Kids, Healthy Michigan Childhood Obesity Prevention Workgroup

Michigan Care Improvement Registry

MCIR

MICHIGAN CARE IMPROVEMENT REGISTRY

Preventing Disease Through Immunization

Reduction of vaccine-preventable diseases through immunization is a top priority for the Michigan Department of Community Health (MDCH). Many people in Michigan receive immunizations from multiple providers. Without access to accurate patient immunization records, providers find it difficult to determine which vaccines are still needed. This can cause over or under immunization.

MCIR Has Expanded to Include Adults

MCIR was created to collect reliable immunization information and make it accessible to authorized users online. In 2006, MCIR was expanded to include adults. By consolidating immunization records into one easily accessible electronic record, providers can actively take the appropriate steps necessary to reduce vaccine preventable diseases in our most vulnerable citizens. MCIR also has the ability to assist with pandemic flu preparedness and can track vaccines and medications

Benefits for Providers

MCIR saves time, money, and eliminates missed vaccination opportunities.

- Easy to access via the web
- Provides immediate patient immunization history and shows what's due
- Recommends future dose dates
- Sends reminder and recall notices for due or overdue immunizations
- Provides quick and easy-to-print official immunization records to meet day care and school requirements

Busy Practices Have Found that MCIR Can:

- Simplify complex immunization schedules
- Help practices manage vaccine supply
- Accept electronic and paper immunization information
- Generate a profile report to determine if it's necessary to increase immunization levels

Benefits for Health Plans

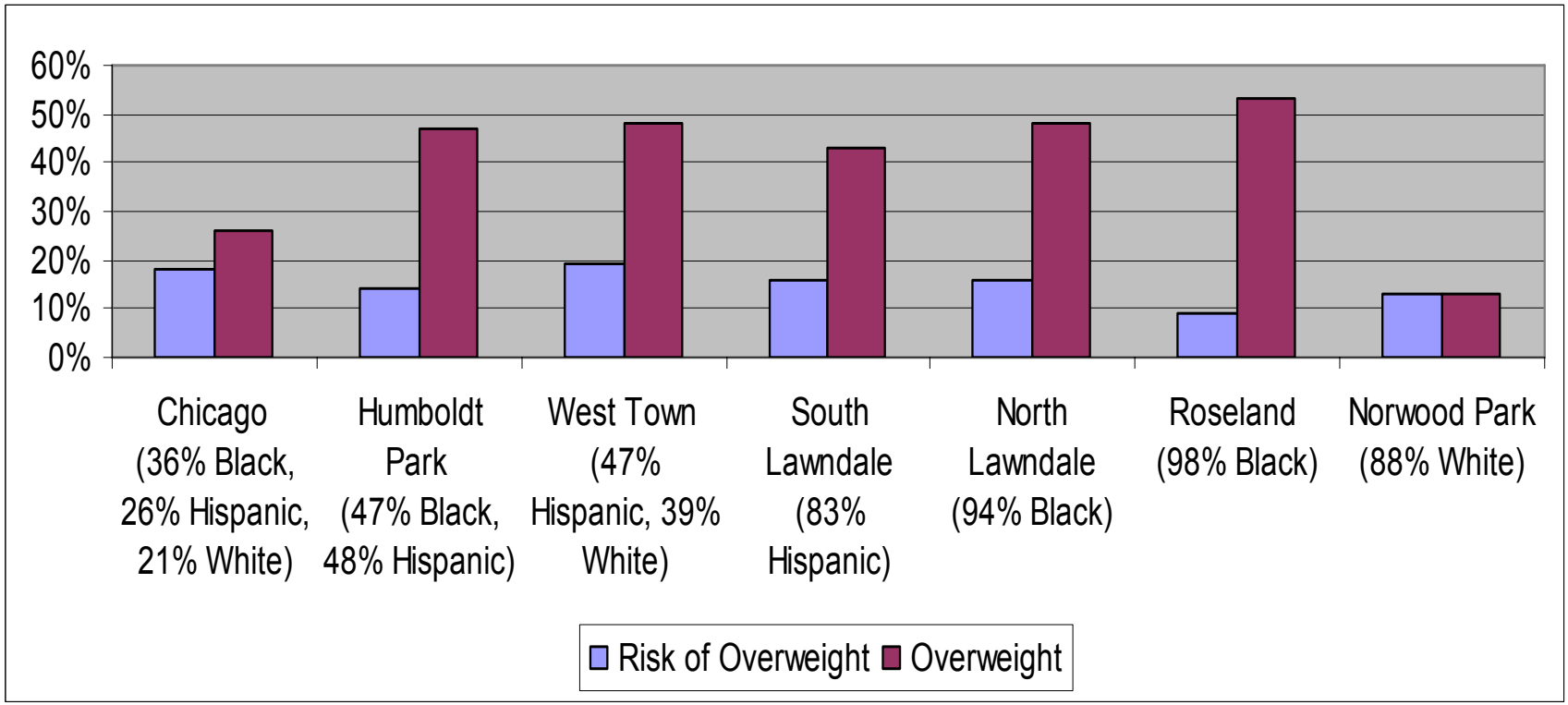
Most Michigan health plans utilize the MCIR/HEDIS extract process to supplement or provide their administrative data for annual HEDIS measurement. Some health plans have had so much success with the MCIR/HEDIS extract data that they have been able to eliminate annual chart audits.

Public Health Benefits

With MCIR, local health departments have the ability to do population-based immunization level assessments and target their outreach efforts where it's needed. MCIR also will provide access to:

- The all-hazard tracking system for emergency preparedness
- Other existing child health databases—such as lead, newborn hearing, and newborn metabolic screening
- The Influenza Vaccine Exchange Network (IVEN)

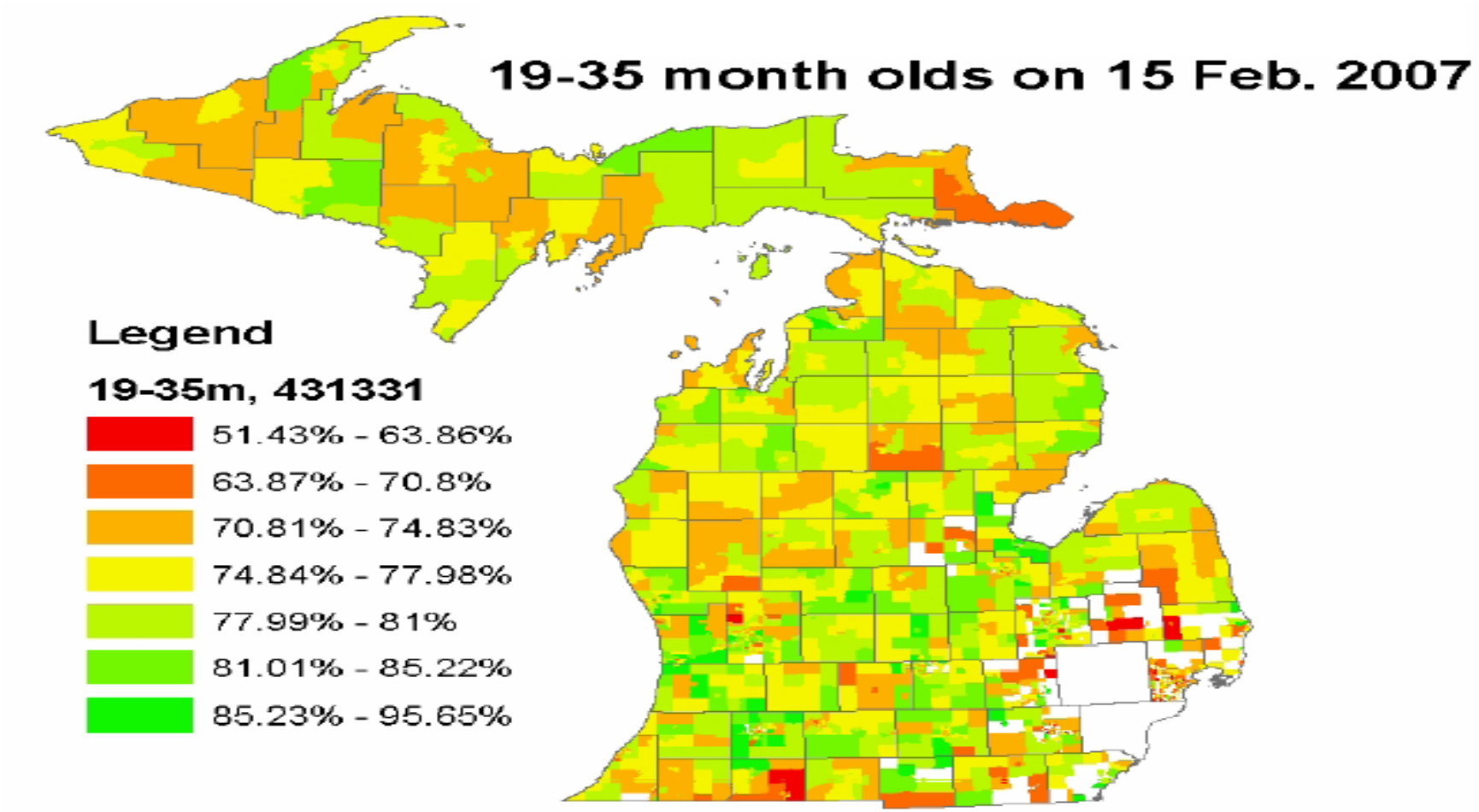
Local Data are Emerging



– Source: M. Longjohn

Sinai Urban Health Institute

Illustrative MCIR Report



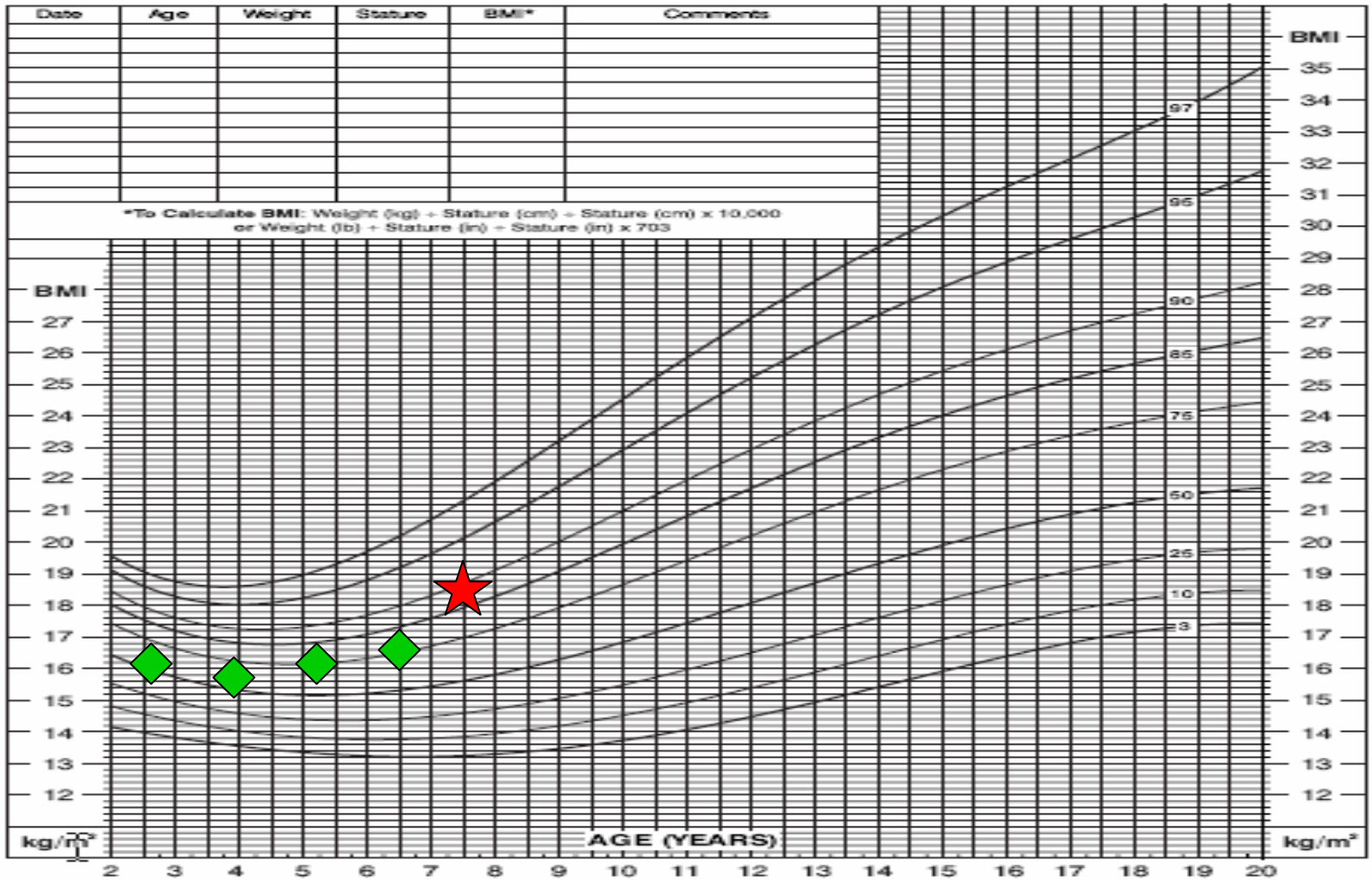
2 to 20 Years: Girls
Body Mass Index for Age Percentiles

NAME _____

RECORD # _____

Date	Age	Weight	Stature	BMI*	Comments

*To Calculate BMI: Weight (kg) ÷ Stature (cm) ÷ Stature (cm) x 10,000
or Weight (lb) ÷ Stature (in) ÷ Stature (in) x 703



Published May 30, 2000 (modified 10/16/00).
SOURCE: Developed by the National Center for Health Statistics in collaboration with the National Center for Chronic Disease Prevention and Health Promotion (2000).

TABLE 8 Weight Goals and Intervention Stages, According to Age and BMI Categories

Age	BMI Category	Weight Goal to Improve BMI Percentile[a]	Initial Intervention Stage	Highest Intervention Stage
<2 y	Weight for height	NA	Prevention counseling	Prevention counseling
2–5 y	5th–84th percentile or 85th–94th percentile with no health risks	Weight velocity maintenance	Prevention counseling	Prevention counseling
	85th–94th percentile with health risks	Weight maintenance or slow weight gain	Prevention Plus (stage 1)	SWM (stage 2)
	≥95th percentile	Weight maintenance (weight loss of up to 1 lb/mo may be acceptable if BMI is >21 or 22 kg/m²)	Prevention Plus (stage 1)	CMI (stage 3)
6–11 y	5th–84th percentile or 85th–94th percentile with no health risks	Weight velocity maintenance	Prevention counseling	Prevention counseling
	85th–94th percentile with health risks	Weight maintenance	Prevention Plus (stage 1)	SWM (stage 2)
	95th–99th percentile	Gradual weight loss (1 lb/mo or 0.5 kg/mo)	Prevention Plus (stage 1)	CMI (stage 3)
	>99th percentile	Weight loss (maximum is 2 lb/wk)	Prevention Plus (stage 1) or stage 2 or 3 if family is motivated	TCI (stage 4), if appropriate
12–18 y	5th–84th percentile or 85th–94th percentile with no health risks	Weight velocity maintenance; after linear growth is complete, weight maintenance	Prevention counseling	Prevention counseling
	85th–94th percentile with health risks	Weight maintenance or gradual weight loss	Prevention Plus (stage 1)	SWM (stage 2)
	95th–99th percentile	Weight loss (maximum is 2 lb/wk)	Prevention Plus (stage 1)	TCI (stage 4), if appropriate
	>99th percentile	Weight loss (maximum is 2 lb/wk)	Prevention Plus (stage 1) or stage 2 or 3 if patient and family are motivated	TCI (stage 4), if appropriate

Barlow, 2007

Implementation Issues

- Develop PDF “pop-ups” with clinical guidance.
- Develop data analysis strategies.
- *Consider requiring schools to report compliance with BMI assessment at age 2, K and 6th grades, as they must do with immunization reporting, if compliance lags?*

Implementation Timetable

- Year 1: Age 2 and Kindergarten
- Year 2: 6th Grade
- Year 3+: 3rd and 9th Grades

Key References

Barlow, S.E. and C. and the Expert, *Expert Committee Recommendations Regarding the Prevention, Assessment, and Treatment of Child and Adolescent Overweight and Obesity: Summary Report.* Pediatrics, 2007. **120**(Supplement_4): p. S164-192.

Institute of Medicine, *Preventing Childhood Obesity: Health in the Balance*. 2005, Washington, D.C.: National Academies Press.

Koplan, J., *Progress in Preventing Childhood Obesity: How do we Measure Up?* 2007, Washington, D.C.: National Academies Press.

National Committee for Quality Assurance, *Body Mass Index (BMI) Percentile Assessment and Counseling for Nutrition and Physical Activity (BCA)*, in *Draft Document for HEDIS 2009 Public Comment*. 2008.

Ryan, K.W., et al., *Arkansas Fights Fat: Translating Research into Policy to Combat Childhood and Adolescent Obesity.* Health Aff (Millwood), 2006. **25**(4): p. 992-1004.

State of Michigan Obesity Prevention Subcommittee of the Cardiovascular Health Advisory Committee, *Preventing Obesity and Reducing Chronic Disease: The Michigan Healthy Eating and Physical Activity Plan*. 2005, State of Michigan.

University of Arkansas for Medical Services / Fay W. Boozman College of Public Health, *Year Three Evaluation: Arkansas Act 1220 of 2003 to Combat Childhood Obesity*. 2007.

Medicaid Coverage of Childhood Obesity

Tom Rifai MD BCPNS

Associate Medical Director

Pritikin Longevity Center

Origins of COPW proposal: MEDICAID Coverage of Specialty Services for Childhood Obesity

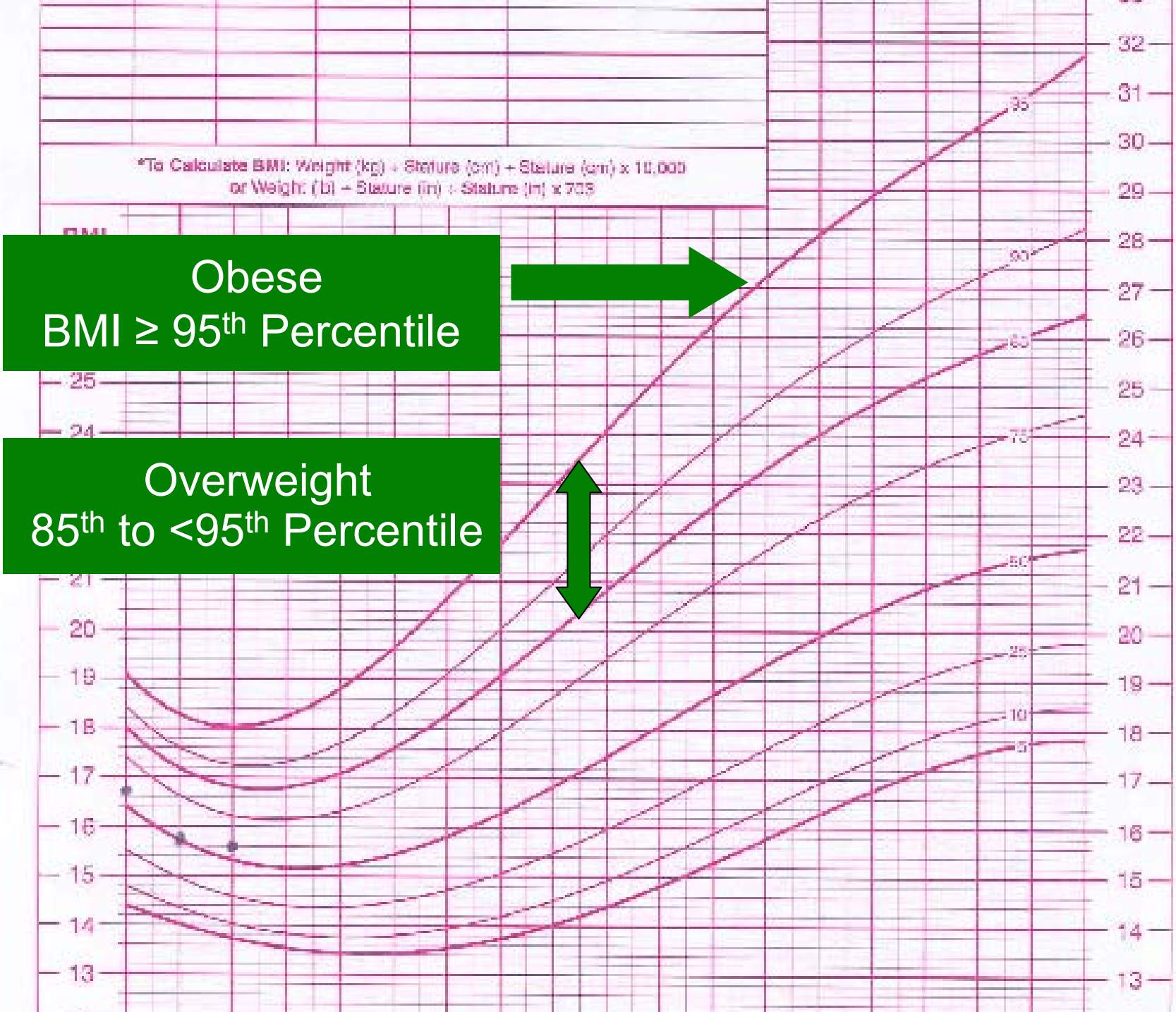
- A major component of effort against obesity is Multidisciplinary Health Care
- Requirement of Medicaid to cover pediatric obesity treatment and prevention is supported through Fed EPSDT mandate
- Outlines for Michigan Medicaid Proposal inspired by 2007 Pediatric Obesity Expert Committee recommendations

Origins of COPW proposal: MEDICAID Coverage of Specialty Services for Childhood Obesity

- Gathered input from state and national experts-RWJF, NGA
- Coverage intended to be comprehensive and to act as a guideline for treatment
- ***Excellent coordination from Karah Mantinan of MDCH***

Secondary Prevention and Treatment of Obesity

Susan J. Woolford, MD, MPH


*To Calculate BMI: Weight (kg) ÷ Stature (cm) ÷ Stature (cm) x 10,000
or Weight (lb) ÷ Stature (in) ÷ Stature (in) x 703
Obese
BMI ≥ 95th Percentile
Overweight
85th to <95th Percentile
95
90
85
75
50
25
10
5
32
31
30
29
28
27
26
25
24
23
22
21
20
19
18
17
16
15
14
13

Boy
16 years old
(average height)

Boy
16 years old
(average
height)

BMI 24.4
85th Percentile

Boy
16 years old
(average
height)

BMI 27.5
95th Percentile

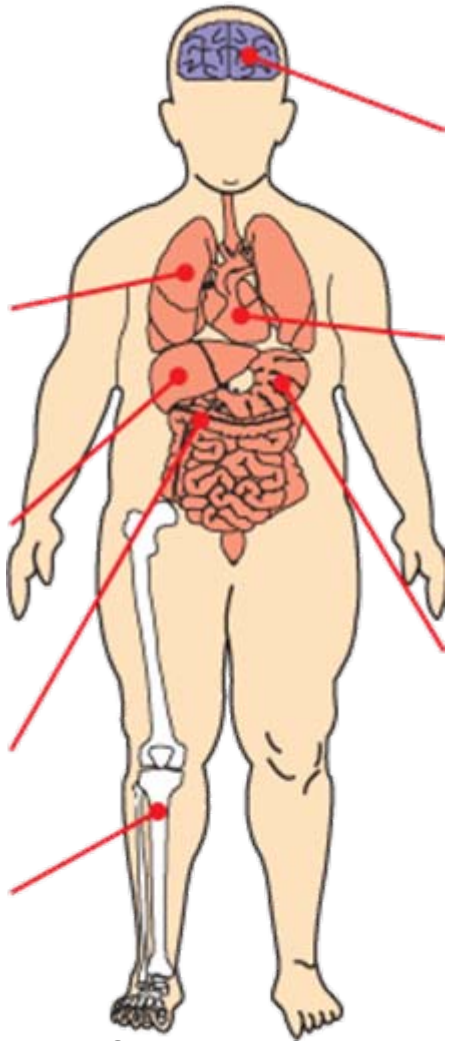
Complications of Obesity

Pulmonary
Exercise Intolerance
Sleep Apnea
Asthma

Gastrointestinal
Gallstones
Gastro-esophageal Reflux
Liver Disease

Renal
Glomerulosclerosis

Musculoskeletal
Slipped Capital Femoral
Ankle Injuries
Tibia Vera (Knock Knees)
Flat Feet



Neurological
Pseudotumor Cerebri

Cardiovascular
High Blood Pressure
High Cholesterol
Chronic Inflammation

Endocrine
Insulin Resistance
Impaired Glucose Tolerance
Diabetes Type 2
Precocious Puberty
Polycystic Ovarian Syndrome

Psychosocial
Poor self-esteem
Depression
Stigmatization

STAGE 1
Prevention
Plus

Providers	Service	Location	Frequency
Primary Care Provider	**Initial Evaluation** History and physical exam Laboratory tests Motivational interviewing (40 mins) Document tailored plan **Follow-up visits** Document BMI Document obesity comorbidities Motivational interviewing (25 mins) Document tailored plan	**Office Setting** Primary care	**1 per year** **5 per year**

Providers	Service	Location	Frequency
Primary Care Provider	**Initial Evaluation** History and physical exam Laboratory tests Motivational interviewing (40 mins) Document tailored plan **Follow-up visits** Document BMI Document obesity comorbidities Motivational interviewing (25 mins) Document tailored **plan**	**Office Setting** Primary care	**1 per year** **5 per year**

Providers	Service	Location	Frequency
Primary Care Provider	**Initial Evaluation** History and physical exam Laboratory tests Motivational interviewing (40 mins) Document tailored plan	Office Setting Primary care	1 per year
	Follow-up visits Document BMI Document obesity comorbidities Motivational interviewing (25 mins) Document tailored plan		5 per year

Providers	Service	Location	Frequency
Primary Care Provider	**Initial Evaluation** History and physical exam Laboratory tests Motivational interviewing (40 mins) Document tailored plan	**Office Setting** Primary care	1 per year
	Follow-up visits Document BMI Document obesity comorbidities Motivational interviewing (25 mins) Document interval history Document defined plan tailored		5 per year

Providers	Service	Location	Frequency
Primary Care Provider	**Initial Evaluation** History and physical exam Laboratory tests Motivational interviewing (40 mins) Document tailored plan **Follow-up visits** Document BMI Document obesity comorbidities Motivational interviewing (25 mins) Document tailored plan	**Office Setting** Primary care	**1 per year** **5 per year**

Providers	Service	Location	Frequency
Primary Care Provider	**Initial Evaluation** History and physical exam Laboratory tests Motivational interviewing (40 mins) Document tailored plan	**Office Setting** Primary care	**1 per year**
	Follow-up visits Document BMI Document obesity comorbidities Motivational interviewing (25 mins) Document tailored plan		**5 per year**

If no BMI decrease after 3 months

STAGE 2
Structured Weight Management

Providers	Service	Location	Frequency
Providers **with training or experience in weight treatment**	**Initial Evaluation** Structured guidelines Meal plans Planned snacks Planned activities **Follow-up visits** Monitor food logs Monitor activity logs **Exercise sessions**	**Office Setting**	***6 Monthly*** **visits/year with PCP** **Plus** **3 hr / year with dietitian** ***and*** **3 hr / year with exercise specialist**

Providers	Service	Location	Frequency
Providers with training or experience in weight treatment	**Initial Evaluation** Structured guidelines Meal plans Planned snacks Planned activities **Follow-up visits** Monitor food logs Monitor activity logs **Exercise sessions**	**Office Setting**	***6 Monthly*** **visits/year with PCP** **Plus 3 hr / year with dietitian** ***and*** **3 hr / year with exercise specialist**

Providers	Service	Location	Frequency
Providers with training or experience in weight treatment	**Initial Evaluation** Structured guidelines Meal plans Planned snacks Planned activities **Follow-up visits** Monitor food logs Monitor activity logs **Exercise sessions**	**Office Setting**	***6 Monthly*** **visits/year with PCP** **Plus 3 hr / year with dietitian** ***and*** **3 hr / year with exercise specialist**

Providers	Service	Location	Frequency
Providers with training or experience in weight treatment	**Initial Evaluation** Structured guidelines Meal plans Planned snacks Planned activities **Follow-up visits** Monitor food logs Monitor activity logs **Exercise sessions**	**Office Setting**	***6 Monthly* visits/year with PCP** **Plus 3 hr / year with dietitian** ***and*** **3 hr / year with exercise specialist**

Providers	Service	Location	Frequency
Providers with training or experience in weight treatment	**Initial Evaluation** Structured guidelines Meal plans Planned snacks Planned activities **Follow-up visits** Monitor food logs Monitor activity logs **Exercise sessions**	**Office Setting**	***6 Monthly* visits/year with PCP** **Plus** **3 hr / year with dietitian** ***and*** **3 hr / year with exercise specialist**

Providers	Service	Location	Frequency
Providers with training or experience in weight treatment	**Initial Evaluation** Structured guidelines Meal plans Planned snacks Planned activities **Follow-up visits** Monitor food logs Monitor activity logs **Exercise sessions**	**Office Setting**	***6 Monthly* visits/year with PCP** **Plus 3 hr / year with dietitian** ***and*** **3 hr / year with exercise specialist**

If no BMI decrease after 6 months

STAGE 3
Comprehensive
Multidisciplinary
Team Care

Providers	Service	Location	Frequency
Pediatric Weight Management team	**Comprehensive, Intensive, family-focused intervention** Behavior modification Goal setting Self-monitoring Systematic evaluation of: Anthropometrics Fitness Dietary intake	**Weight Management Center**	**Monthly** ***with Physician*** **Weekly x 12 wks then monthly** ***with other team members***

Providers	Service	Location	Frequency
Pediatric Weight Management team	**Comprehensive, Intensive, family-focused intervention** Behavior modification Goal setting Self-monitoring Systematic evaluation of: Anthropometrics Fitness Dietary intake	Weight Management Center	**Monthly** *with Physician* **Weekly x 12 wks then monthly** *with other team members*

Providers	Service	Location	Frequency
Pediatric Weight Management team	**Comprehensive, Intensive, family-focused intervention** Behavior modification Goal setting Self-monitoring Systematic evaluation of: Anthropometrics Fitness Dietary intake	**Weight Management Center**	**Monthly** ***with Physician*** **Weekly x 12 wks then monthly** ***with other team members***

Providers	Service	Location	Frequency
Pediatric Weight Management team	**Comprehensive, Intensive, family-focused intervention** Behavior modification Goal setting Self-monitoring Systematic evaluation of: Anthropometrics Fitness Dietary intake	Weight Management Center	**Monthly** ***with Physician*** **Weekly x 12 wks then monthly** ***with other team members***

Providers	Service	Location	Frequency
Pediatric Weight Management team	**Comprehensive, Intensive, family-focused intervention** Behavior modification Goal setting Self-monitoring Systematic evaluation of: Anthropometrics Fitness Dietary intake	**Weight Management Center**	**Monthly** ***with Physician*** **Weekly x 12 wks then monthly** ***with other team members***

Some *severely* obese adolescents after 6 months

STAGE 4
Tertiary Care

Providers	Service	Location	Frequency
Pediatric Weight Management Team	Medication Very low-calorie diet Surgical intervention	Weight Management Center	Up to *Weekly*

Providers	Service	Location	Frequency
Pediatric Weight Management Team	Medication Very low-calorie diet Surgical intervention	Weight Management Center	Up to *Weekly*

Providers	Service	Location	Frequency
Pediatric Weight Management Team	Medication Very low-calorie diet Surgical intervention	Weight Management Center	Up to *Weekly*

Providers	Service	Location	Frequency
Pediatric Weight Management Team	Medication Very low-calorie diet Surgical intervention	Weight Management Center	Up to *Weekly*

Michigan's Answer is

NO!

	Providers *(Who)*	Services / Codes *(What)*	Location *(Where)*	Frequency *(When)*
STAGE 1 ***If no BMI decrease after 3 months***	**Primary Care Provider (PCP)** Physician Nurse practitioner (NP) Physician assistant (PA)	**Initial Evaluation – level 4 or 5 (99214 or 99215)*** **History of present illness** **Family and social history** **Review of systems** **Physical exam** **Laboratory tests (if age ≥ 10 yrs)** **Counsel using motivational interviewing (40 mins)** **Document defined plan tailored to family** **Follow-up visits – level 3 or 4 (99213 or 99214)** **Document BMI, obesity comorbidities/health risks** **Counsel using motivational interviewing (25 mins)** **Document interval history and defined plan tailored to family**	**Office Setting** Primary care	***6 visits per year*** **1 Initial Evaluation** **5 Follow-up visits**
STAGE 2 ***If no BMI decrease after 6 months***	**Providers experienced / trained in weight management and Motivational Interviewing** Physician / NP / PA Registered Dietitian with pediatric certification **Exercise Specialist** Exercise physiologist Physical therapist	**Initial Evaluation as above plus, initiate** **Structured guidelines and meal plans** **Planned snacks and activities** (Typically level 4 or 5, CPT 99214 or 99215; if with a dietitian CPT 97802) **Follow-up visits as above plus** **Monitor food and activity logs** (Typically level 3 or 4 CPT 99213 or 99214; with dietitian reassessment and intervention individual 97803 or group 97804) **Exercise specialist sessions (97530)**	**Office Setting** Primary care Dietitian Exercise specialist	***6 Monthly* visits per year with PCP** **Plus** **3 *hours* per year with dietitian** **and** **3 *hours* per year with exercise specialist**
STAGE 3 ***Some severely obese adolescents after 6 months***	**Pediatric Multidisciplinary Weight Management team** Physician / NP / PA Registered Dietitian (RD) Exercise Specialist (ES) Behavioral specialist (BS)	**Comprehensive, Intensive, family-focused intervention** Including behavior modification, goal setting, self-monitoring, and systematic evaluation of anthropometric measures, fitness, and dietary intake.	**Weight Management Center**	**Physician – *Monthly*** **RD, ES, or BS – *Weekly* x 12wks** **then *monthly***
STAGE 4 *Tertiary Care*	**Pediatric Multidisciplinary Weight Management team**	**Medication use (i.e., Sibutramine or Orlistat)** **Very low-calorie diet** **Surgical intervention (gastric bypass or banding)** (BMI ≥ 40 kg/m^2 with ≥ 2 severe comorbidities, or ≥ 50 kg/m^2 with ≥ 2 less severe comorbidities)	**Weight Management Center**	**Up to *Weekly***

Child Care Policy Recommendations

Richard Lower

Executive Director

Michigan Head Start Association

Child Care Policy Subcommittee Members

- Keith Myers, Executive Director, Michigan Association for the Education of Young Children
- Mary Rice, Executive Director, Association for Child Development
- Judy Levine, Education Consultant, Michigan Department of Education

Child Care: An Important Setting to Reach Michigan Children **Early**

- In the US, 74% of 3-6 year olds are in child care
- In Michigan, centers and family group homes serve 359,561 children
- Large proportion of children's day spent in child care
  - Consume 50-100% of Recommended Dietary Allowances in child care setting
  - Nutrition attitudes are shaped by non-family members
  - *Should* be given opportunities for physical activity

Child Care Recommendation #1:
Implement a 60 minutes per day minimum physical activity requirement for all licensed child care

- Consistent with national recommendations from CDC, AMA, etc.
- No mandatory state policy for physical activity that covers children in all regulated licensed child care settings.

Child Care Recommendation #1:
Implement a 60 minutes per day minimum physical activity requirement for all licensed child care

- Pros:
  - Touch tens of thousands of children each year in various child care settings across state;
  - No- to low-cost for implementation and monitoring for the state as well as for the provider;
  - Requires no major changes in law and can be achieved through regulatory process (similar to 30 minute reading requirement implemented by Governor Granholm during her first term).
  - Can be achieved immediately in short term (i.e., 1st or 2nd year of Agenda).

Child Care Recommendation #2:

Provide financial incentives for child care providers to serve fresh fruits and vegetables

- USDA reimburses child care providers for meals and snacks served.
- Nutrition standards not very stringent-cookies, cakes, brownies, are reimbursable.
- Reimbursement rates can be a disincentive for serving more nutritious foods due to current market costs (cheap, packaged foods vs. fresh fruits and vegetables).
- High energy dense food are associated with obesity.

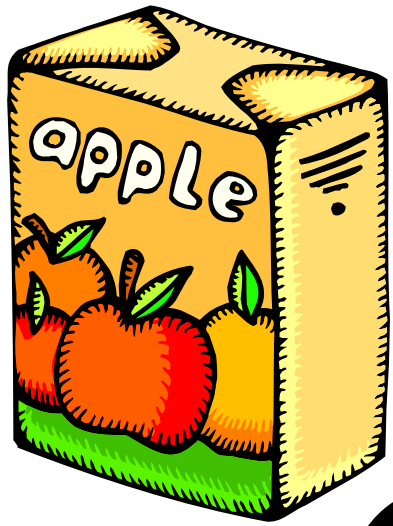
Child Care Recommendation #2:
Provide financial incentives for child care providers to serve fresh fruits and vegetables

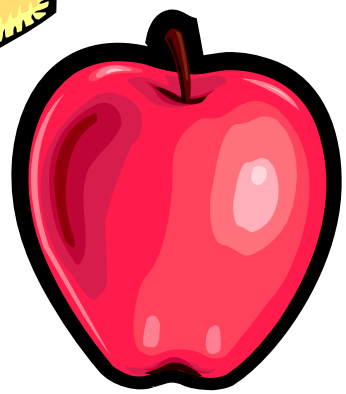
- **Pros:**
  - Children will have access to fresh fruits and vegetables instead of packaged, highly processed foods;
  - Assist children in establishing healthier dietary habits and food preferences earlier in life;
  - Minimal costs to implement and monitor by the state;
  - Requires no major changes in law and can be achieved through regulatory and state budget processes.
- **Cons:**
  - Cost-where will the state come up with dollars to fund the financial incentives?
  - Can be implemented over a longer period of time in the Agenda, with incremental increases made each year.

Child Care Recommendation #3:

Remove juice as a reimbursable option every time a fruit or vegetable is required

- Fruits-vegetables-juice is a food group category.
- USDA reimbursement rates may be a disincentive for serving fresh, whole fruits and vegetables due to current market costs-juice can be cheaper than whole fruits
- Expert recommendations to limit juice to 4 oz/day 100% juice.
- Sugar sweetened beverage consumption increases risk of obesity.





Child Care Recommendation #3:

Remove juice as a reimbursable option every time a fruit or vegetable is required

- **Pros:**
  - Children will have access to fresh fruits (associated with decreased obesity);
  - Will assist children in establishing healthier dietary habits and food preferences earlier in life;
  - Low- to no-cost for implementation and monitoring by the state;
  - Requires no major changes in law and can be achieved through regulatory process;
  - Energy density studies would argue for consuming whole fruits and vegetables instead of juices.
- **Cons:**
  - Additional cost on part of provider determined by current market costs;
  - Evidence for fruit juice and obesity is equivocal.
  - Can be implemented in the short term-second or third year of Agenda.

Policies that Affect Families

Daniel C. Stettner, Ph.D.
UnaSource Health Center
Troy, Michigan

Workgroup Discussions

- Encouraging families during stressful times
- Increasing parent participation in healthy family activities
- Financial supports for good nutrition
- Parent education about child nutrition
- Reinforcing parent control of health behaviors

Family Problem Areas

- Inconsistent meal times and choices
- Low parent caring about health behaviors
- Inconsistent parent recognition of health problems among children
- Inadequate screen/viewing management
- Lack of following school/medical guidelines for health behaviors

Strategies for Implementation (vs. Policy Recommendations)

- Parent education beginning with infants
- Pediatrician supports for health screenings
- Support for parent nutrition training
- School curriculum iniatives
- Fitness availability for children and teens
- Continued management of screen time

Health, Family and Child Care Services Policy Action Team

Q & A

Community Policy Action Team

Kirsten Simmons

Executive Coordinator

Michigan Food Policy Council

Participants

- Associated Food and Petroleum Dealers, Inc.
- Greening of Detroit
- League of Michigan Bicyclists
- Meijer, Inc.
- MI Apple Committee
- MI Assoc. of Neighborhoods
- MI Assoc. of Planning
- MI Dept. of Community Health
- MI Dept. of Education
- MI Dept. of Transportation
- MI Environmental Council
- MI Farm Bureau
- MI Farmers Market Assoc.
- MI Fitness Foundation
- MI Food Policy Council
- MI Mountain Biking Association
- MI Nutrition Network
- MI Restaurant Assoc.
- MI Recreation and Park Assoc.
- MI State Housing Development Authority
- MI State University
- MI Suburbs Alliance
- MI Township Assoc.
- MI Trails and Greenway Alliance
- Spartan Stores
- University of Michigan School of Public Health

Background - Process

- Brainstormed
- Researched legislation in other states, scientific support and best practices
- Organized the policy ideas into categories
- Surveyed team on policy ideas to narrow down the ones important to impact and feasibility
- Continued to research
- Developed a matrix and resurveyed based on political environment, impact, feasibility, and current support

Community Healthy Eating Policy Recommendations

- School Gardens
- Summer Food Service Program
- Supermarkets in Underserved Areas
- Farmers Markets and Retail Outlets with Fresh Food

Community Healthy Eating Policy Recommendations

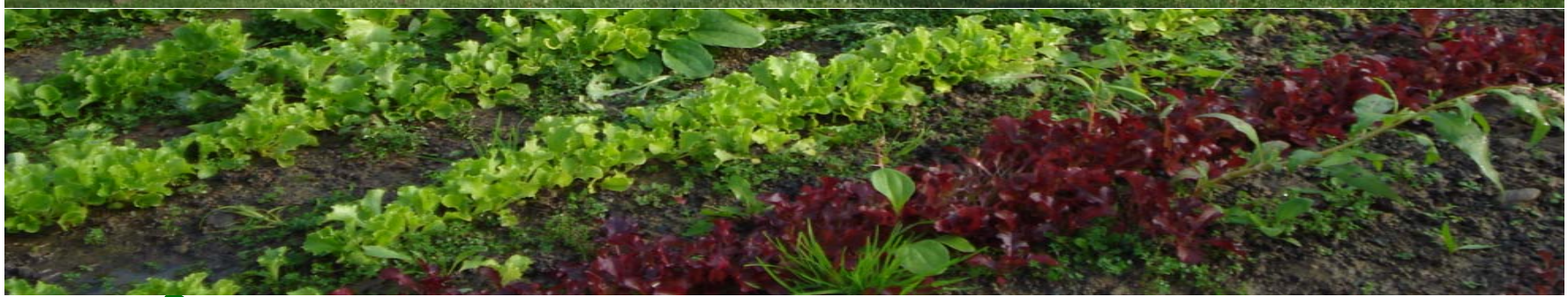
Policy 1: School Gardens

-Students grow produce in an instructional setting

-Schools sometimes partner with community groups

-Studies show that children who plant and harvest their own fruits and vegetables are more likely to eat them.

Recommendations – School Gardens



Recommendations

School Gardens - Cons

- People to manage the growing and maintaining of the garden
- Michigan growing season does not match up with academic year
- Might meet with resistance from some school officials
- State of Michigan financial hardships

Recommendations

School Gardens - Pros

- Food grown in the garden can be served in the cafeteria
- Children grow, eat and learn about nutrition
- Engages students in a dynamic environment
- Shows our youth the connection between land, food, and health

Recommendations

School Gardens – Pros

California: <u>Garden in Every School Initiative</u>:

- Established in 1995
- Led by California Dept. of Education's Nutrition Services Division
- Utilizes community partnerships

Recommendations

-Assembly Bill 1014 of 1999 – establishes instructional school garden program

-Senate Bill 19 of 2001 – identifies school gardens as one way to increase student preferences for fresh fruits and vegetables

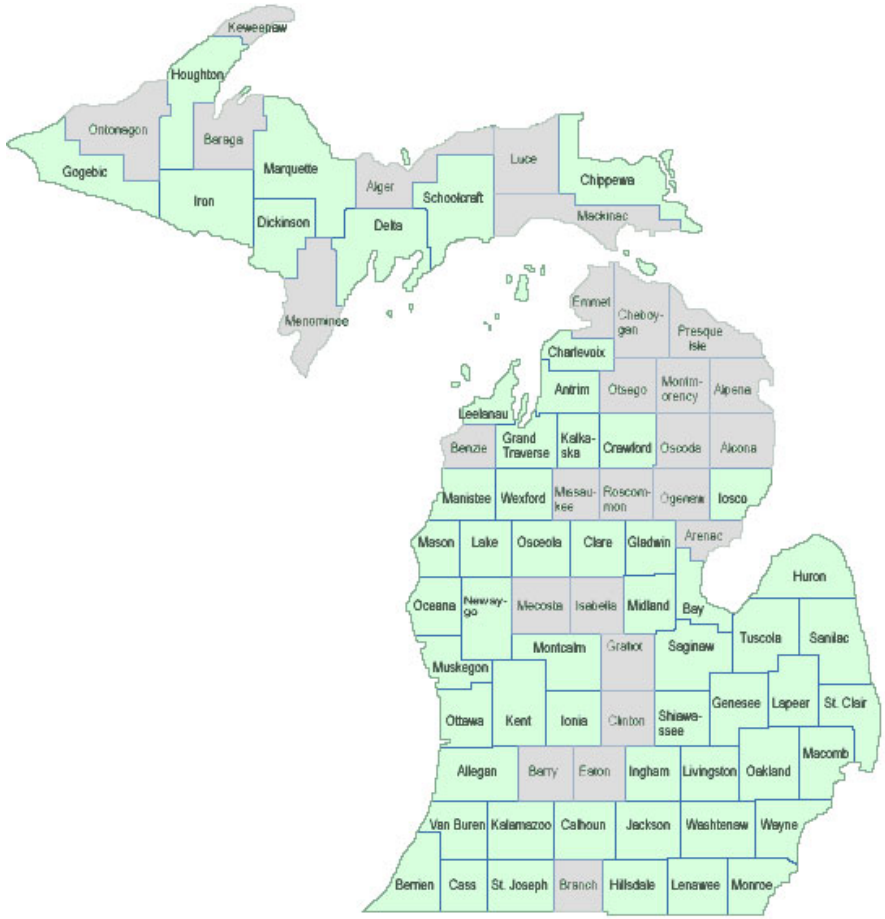
-Assembly Bill 1535 of 2006 – authorizes the CA Dept. of Education to award $15 million for grants to promote, develop, and sustain instructional school gardens

Community Healthy Eating Policy Recommendations

Policy 2: Summer Food Service Program

- Sponsors receive payments for serving healthy meals and snacks
- Children benefit nutritionally by receiving complete, wholesome meals
- Studies show that the risk of obesity decreases with participation in school meal programs

Recommendation – Summer Food Service



Recommendations

Summer Food Service Program - Cons

- Association between food insecurity and obesity in children is equivocal and thus, policy changes for food assistance programs may not be effective for reducing childhood obesity
- Districts may not support a mandate
- State of Michigan financial hardships

Recommendations

Summer Food Service Program – Pros

- Encourages community groups to partner with schools
- Providing healthful options could slow summer weight gain
- Brings federal dollars to the state

Recommendations

State	Additional Children	Dollars Lost
Texas	621,316	$34,576,231
Florida	233,750	$13,008,198
Georgia	165,297	$9,198,760
California	156,209	$8,693,021
Illinois	149,346	$8,311,116
Ohio	141,532	$7,876,232
North Carolina	137,784	$7,667,661
Michigan	123,455	$6,870,255
Louisiana	117,931	$6,562,846
New York	115,402	$6,422,127

Source: Food Research and Action Center. Hunger Doesn't Take a Vacation: Summer Nutrition Status Report, 2007.

Recommendations

Summer Food Service Program – State and National Recommendations

-Food Research and Action Center: Require schools to offer summer meals if one or more of the district's schools has 50% or more of students who qualify for free or reduced school meals, or if the district is operating summer school.

-Michigan Food Policy Council: Improve access to fresh and/or healthy foods for low-income children through the Summer Food Service Program.

Recommendations

Summer Food Service Program – Legislative Picture in Numbers

11 ⇨ Number of states that have passed legislation to provide state funds for purposes related to the Summer Food Service Program

7 ⇨ Number of states that mandated all or certain schools must participate in the Summer Food Service Program

Community Healthy Eating Policy Recommendations

Policy 3: Supermarkets in Underserved Areas

-Underserved areas, sometimes referred to as food deserts, have a high rate of diet-related disease including obesity

-Research shows many low-income neighborhoods lack healthy, affordable retail food options.

-Buying healthy food often involves transportation that is inconvenient or unavailable to many residents.

Recommendations

Supermarket Incentives – Cons

– May not be the only incentive or assistance required in certain communities

- Must have interested developers or be proactive about outreach

Recommendations

Supermarket Incentives - Pros

- Serves to draw in interested developers
- Supermarkets in underserved areas would combat food insecurity in families, including those using a Bridge Card

Recommendations

Supermarket Incentives – Previous Michigan Legislation: <u>Senate Bill 294 (Senator Mark Jansen):</u>

-Amends the Commercial Rehabilitation Act to include grocery store, as a qualified facility under the Act.

-No significant negative impact on local or state government

-Tax incentives are one part of the Michigan Food Policy Council's recommendation for grocery stores in underserved areas

Community Healthy Eating Policy Recommendations

Policy 4: Farmers Markets and Retail Outlets

-Farmers markets run by community groups or local government

-Local convenience stores and liquor stores – no fresh food or limited quantity

Recommendations – Farmers Markets and Retail Outlets

Recommendations

Farmers Markets and Retail Outlets – Cons

- Staff and coordination
- State of Michigan financial hardship
- Public transportation
- Retail outlets stock shelves with the kind of food in demand

Recommendations

<u>Farmers Markets</u> and Retail Outlets - Pros

- Provide a source of fresh food where grocery store development is not feasible.
- Markets could provide one more location where Bridge Cards are accepted
- Support for a solution by the Robert Wood Johnson Foundation

Recommendations

Farmers Markets and <u>Retail Outlets</u> - Pros

- Convenience stores are often a source of food for families in low-income areas
- Provides the option for an alternative to processed food or unhealthy packaged snacks
- Would allow for demand for certain products

Recommendations

Farmers Markets and Retail Outlets: The Pennsylvania Example

- The Food Trust – Farmers Market Program
- Farmers' Market Development Act

Recommendations

Farmers Markets and Retail Outlets: The Maine Example

- State law requires a program to promote the purchase of state food products at local farmers' markets by nutritionally at-risk groups.

Recommendations

Farmers Markets and Retail Outlets: The California Example

Good Neighbor Initiative

-Bay view-Hunter's Point Neighborhood

-Incentives for stores to carry more fresh produce include free refrigerated units, cooperative purchasing, and business training

-Funded through a partnership

Community Action Team Physical Activity Policy Recommendations

Risa Wilkerson
Governor’s Council on Physical Fitness

Community Physical Activity Policy Recommendations

- Transportation and Infrastructure Reform
- Planning and Zoning Reform
- Facilities and Operations Reform

Community Physical Activity Policy Recommendations

Transportation and Infrastructure Reform Policies:

- **Complete Street Plans**
- **Safe Routes to School Plans**
- Regional and Community Pedestrian and Bicycle Plans

Community Physical Activity Policy Recommendations

Planning and Zoning Reform Policies:

- **School Siting**
- Community/Local Comprehensive Plans
- Financial Incentives related to Active Living

Community Physical Activity Policy Recommendations

Facility and Operations Reform Policies:

- Support Recreation Centers, Parks, Trails and Greenways
- Expand Access Of School Facilities
- Indoor and Outdoor School Facility
- Master Plans to Include Recreation Opportunities

Recommendations

Policy 1: Complete Streets

- Streets accommodate all users including pedestrians, bicyclists, transit vehicles and users, and motorists of all ages and abilities.
- Community is connected with businesses, schools, retail, and other key destinations.

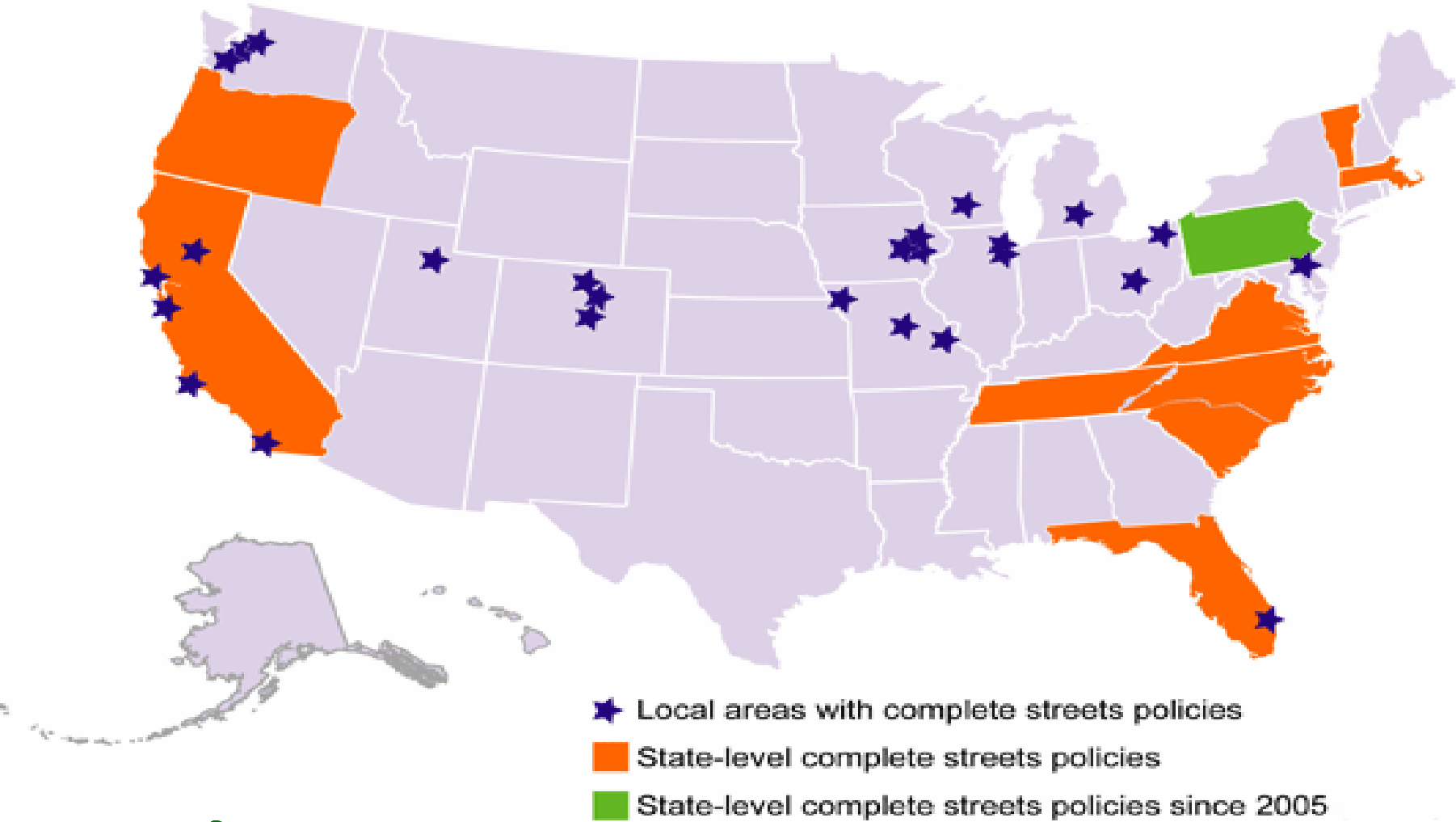
Healthy Kids, Healthy Michigan Ch

Recommendations

Complete Streets - Cons

- It requires retooling our transportation philosophy.
- Michigan was developed as an automobile state.
- Right of way constraints.

Recommendations - Complete Streets



Recommendations

Complete Streets: Pending Federal Legislation

- Implemented in **2 years** after the date by States and Metropolitan Planning Organizations.
- Adopt an explicit statement of policy.
- Apply policy to the projects contained in the Transportation Improvement Program.
- Incorporate the principles in this policy into all aspects of the transportation planning.

Recommendations

Complete Streets – Pending Federal Legislation Supporters:

AARP, America Bikes, America Walks, American Council of the Blind, American Planning Association, American Public Transportation Association, American Society of Landscape Architects, Association of Pedestrian and Bicycle Professionals, League of America Bicyclists, National Center for Bicycling and Walking, Safe Routes to School National Partnership, Smart Growth America, Surface Transportation Policy Partnership, Thunderhead Alliance, and Rails to Trails Conservancy

Recommendations

Complete Streets - Pros

- Complete streets provides students access to "active living".
- Sustainable long term solution.
- "It's an equitable solution."

Recommendations

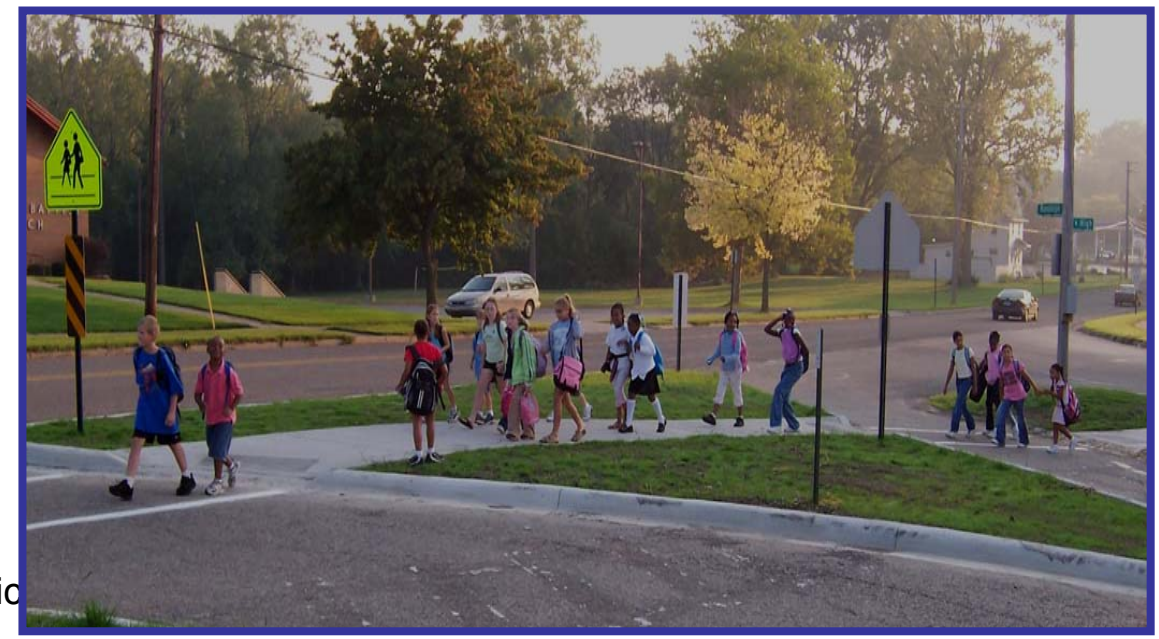
Complete Streets - Pros

- Residents are 65% more likely to walk when sidewalks exist.
- Toronto reported a 23% increase in bicycle traffic after the installation of bicycle lanes.
- Environmental Protection Agency reports the built environment influences travel choices. Students traveling through pedestrian-friendly environments are more likely to walk or bike.

Recommendations

Policy 2: Safe Routes to School Plans

- Require adoption of safe routes to school plans.
- Connect the residential areas to the school campuses via sidewalks, bicycle lanes, pathways, trails.
- Improve safety of the students' routes with lighting, traffic calming, signage, facilities, enforcement, signals, etc.



Recommendations

Safe Routes to School Plans – Cons

- Schools are often located in isolated areas of the community.
- Schools are often not connected to the residential areas.
- Culturally, this is not a common practice (safety and convenience).

Recommendations

Safe Routes to School Plans - Pros

- Federal appropriation funding safe routes to school in every state.
- According to Centers for Disease Control and Prevention, Safe Routes to School is a promising practice.
- Healthy People 2010 goal is to have 50% of students walking to school.

Recommendations

Policy 3: School Siting

- Require that new school siting plans favor locations that are safely accessible by multiple modes of transportation, including walking and biking.
- Encourage community connections related to the location of schools.

Recommendations

School Siting Plans - Cons

- Competition for students.
- Cost of land influences decisions.
- Schools recruit residents and businesses.

Recommendations

School Siting - Pros

- The Institute of Medicine cites the decrease in walking and biking to school as one of the major contributors to childhood obesity. Among 6-11 year olds, obesity has tripled over the last three decades.
- Centers for Disease Control and Prevention reports that distance to school is the most commonly reported barrier to walking to school.
- Environmental Protection Agency reports that students with a shorter walk and bike times to school are more likely to walk or bike.
- Michigan has a Senate and House Bill addressing school site plans.

Community Physical Activity Policies are a MUST!

Marin County, California Safe Routes to School Program

- 64% increase of walking to school
- 114% increase of bicycling to school
- 13% decrease in single occupancy vehicle use around the schools

Community Physical Activity Policies are a MUST!

- Centers for Disease Control and Prevention recommends community-scale urban design and land use policies and practices to increase physical activity.
- 12 studies including these practices showed an increase physical activity by 161%.
- Arlington improved their environment around schools and provided education to now be able to report that more than half of their students walk to school daily.

Community Policy Action Team

Q & A

Future Strategies for the Childhood Obesity Prevention Workgroup

Matt Longjohn

Consensus Results: The Priority Policies

Kimberlydawn Wisdom

Michigan Surgeon General